Pediatrics at the Meadows P.C
Pediatric & Adolescent Healthcare

# CHILD CONSENT FORM FOR SEASONAL INFLUENZA (FLU) VACCINE

**Caregiver Name:**_____ **Child Name:** _____
**(FIRST) (MIDDLE) (LAST)**

Child's Birthday____/____/____& Age_____(if applicable)

Is your child 6 months of age or older? ☐ YES ☐ NO **(If "no," your child may not receive the vaccine at this time.)**

Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, chickens, or chicken feathers? ☐ YES ☐ NO

Does the person receiving the vaccine have a history of Guillain-Barré syndrome or a persistent neurological illness?

☐ YES ☐ NO

Has the person received a live vaccine within the past 30 days (i.e. MMR, RotaTeq/Rotarix)? ☐ Yes* ☐ No

***If YES, it is recommended to space live vaccines by ≥ 4 weeks for full efficacy***

Is the person receiving the vaccine pregnant? ☐ YES ☐ NO

Is the person receiving the vaccine allergic to Neomycin, Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex? ☐ YES ☐ NO

For children 6 mo-8 yrs: Have they received 2 or more doses of influenza vaccine since July 2015? ☐ YES ☐ NO
**(If no, the child will need to receive 2 vaccinations [at least one month apart] for the best protection against flu.)**

For children and adolescents aged 2-17 yrs: Is the child taking long-term aspirin or aspirin-containing therapy?

☐ YES ☐ NO

_____ _____

**Signature of person receiving vaccine OR Parent/Guardian** **Date**

**VERY IMPORTANT – PLEASE PRINT PARENT NAME:** _____

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming here today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to my child.

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**DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY VIS Edition Provided:** _____

Lot number: _____ Expiration Date:_____ CHECK ONE:

____0.5 mL IM Influenza Virus Vaccine given in____left____right deltoid – TIV or QIV
____0.5 mL IM Influenza HIGH Dose Virus Vaccine given in____left____right deltoid (65+) TIV-SR
____0.5mL Intradermal Virus Vaccine site_____- TIV
____0.5mL FluBlok Influenza Virus Vaccine given in____left____right deltoid
____Children 6-35 months: 0.25 mL/dose given in____left____right deltoid (1 or 2 doses per season)
____Children 3-8 years: 0.5 mL/dose given in____left____right deltoid (1 or 2 doses per season)
____Children older than 9 years: 0.5 mL/dose given in____left____right deltoid (1 dose per season)

_____ _____ _____

Nurse/ Provider's Signature Date Time