Flu Vaccine--Minor Consent Form

Minor Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone #: _____

Signature: _____ Date: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Consent:

☐ I declare that I am the parent/legal guardian of the above-named minor child.

☐ I have read and understand the Vaccine Information Statement for the influenza vaccine.

☐ I give consent to bill the influenza vaccine through my pharmacy benefits plan.
(If you do not have benefits available, you will not receive any out-of-pocket cost.)

☐ I give consent for the above-named minor child to receive the influenza vaccine with or without a parent/guardian being physically present.

☐ I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine, including but not limited to itching, swelling, fainting, anaphylaxis, and other reactions.

Please circle your answer to the following questions:

1. Have you received the flu vaccine before?	NO	YES
2. Did you have any problems with the previous flu shots?	NO	YES
3. Do you have allergies to eggs or thimerosal preservative?	NO	YES
4. Are you ill today?	NO	YES
5. Do you have a history of Guillain-Barre syndrome?	NO	YES
6. Do you suffer from asthma?	NO	YES
7. Do you have any immunodeficiency disease?	NO	YES
8. If you are under age 9, have you received the flu vaccine before?	NO	YES

For Internal Use Only:

Vaccine Manufacturer:_____ Lot#:_____

Site: ❑ Left deltoid ❑ Right deltoid ❑ Dose: 0.5 mL ❑ Nasal Exp Date:_____

Signature:_____(RN/LPN/PA) Date Given:_____

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