



PEDIATRIC PARTNERS

VALLEY VIEW

PATIENT CONSENT FOR INFLUENZA VACCINE

Do you have Medicaid **Yes** **No**

Is the person receiving the vaccine a patient of Pediatric Partners **Yes** **No**

Please Print: Last name: _____ First name: _____ MI: _____

Date of Birth: _____ Age: _____ Allergies: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Has the patient ever had a flu vaccine before: Yes No

Children less than nine years of age, who have not previously had the flu vaccine or a physician-documented case of the flu, will require two doses of the vaccine for complete coverage.

We cannot guarantee we will be able to provide the second dose.

Has the patient ever had any of the following:

Please Circle

- | | |
|--|-------------|
| • A serious allergic reaction to a Previous dose of influenza vaccine. | Yes No |
| • A history for Guillain-Barre Syndrome (GBS) | Yes No |
| • Does the patient currently have a fever, respiratory illness or any type of infection? | Yes No |
| • A bad reaction to another vaccine
Please list the reaction _____ | Yes No |

I have received the influenza vaccine information statement and understand the benefits and risks of the vaccine and ask that the vaccine be given to the person named above. I agree that Pediatric Partners shall have no responsibility or liability if the above person contracts influenza, pneumonia, or other respiratory disease or suffers any adverse reactions following administration of the flu vaccine.

Signature of Responsible Person: _____ Date _____

For office use only

For office use only

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Date vaccine and VIS given _____ Date of VIS _____ Contraindications _____

Patients 6 months and older

Lot# _____
Exp date _____
Site _____

☐ **VFC**

☐ **PRIVATE**

☐ **PAID (parent)**

Signature of Administrator _____

\$25 Due at Time of Service for Non-Patients