Southdale Pediatric Associates, Ltd.

Influenza Vaccine Consent Form

Date: ____________________

PATIENT NAME: ____ **Birth Date:** _______________
(Last Name) *(First Name)*

If patient is < 18 yrs, please ***print*** the Legal Name of person responsible for medical decisions**:**

Responsible Person: ____
(Last Name) (First Name)

Relationship to Patient: _________________

I have been given a copy and have read or have had explained to me the information in this pamphlet (Vaccine Information Statement/VIS) about the disease and vaccine(s) indicated below. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the indicated vaccine(s) being given to me.

Does/Has the person named above	YES	NO
have an allergy to eggs (cannot eat eggs baked in foods) and/or thimerosal or latex		
ever had a serious allergic reaction or other problem after getting influenza vaccine		
ever had Guillian-Barre Syndrome		
have a moderate or severe illness today		

If you answered YES to any of the above you will need to consult a physician prior to receiving the flu vaccine.

Signature of person to receive vaccine or the person authorized to make the request (e.g., authorized representative or legal guardian):

X____ **Date**______________________

OFFICE USE ONLY:

Date:______________ **Time:**__________________ **Performed By:**________________________

Route: IM

Dose: **Syringe (Pres. Free)** **0.25** **90685** **0.5** **90686**

Vial Multidose (Pres.) **0.25** **90687** **0.5** **90688**

Site: **L Deltoid** **R Deltoid** **L Thigh** **R Thigh**

Manufacturer: **Sanofi** **Lot #:** **Exp. Date:**

VFC: **VIS Date:**

SDPA129 8/14