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**
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) 0.5 90686

Site: L Deltoid R Deltoid L Thigh R Thigh

Manufacturer: Sanofi Lot #: Exp. Date:

VFC: VIS Date: