

2017-2018 FLU VACCINE SCREENING AND CONSENT



Patient Name: _____

Allergies List: _____

Known Latex Allergy? () Yes () No

DOB: _____

Age: _____

YES	NO	Screening Questions
		Do you (your child) have a fever over 100°?
		Do you (your child) have a cold or any infections?
		Have you (your child) had a reaction to a previous flu vaccine?
		Are you (your child) currently on any medications?

**** Please note that any 'yes' response, a provider needs to be consulted.**

Consent

I have been provided a copy of and have read the Influenza Vaccine Information Sheet [VIS]. I have answered the Health Screening questions above. I understand the benefits and risks of the Seasonal Influenza Vaccination and ask that the vaccine be administered.

Signature of Parent/Legal Guardian: _____

Date: _____

Additional Notes: