CORNERSTONE
PEDIATRIC & ADOLESCENT MEDICINE

2017-2018 Flu Vaccination Consent Form

(Please fill out one information sheet per child)

Patient's Name: _____ Date of Birth: _____

Has this child ever been seen by one of our Providers before? ☐ **Yes** ☐ **No**
If not, please schedule a well child check with one of our providers within two weeks of receiving flu vaccine.

Has the patient ever had the seasonal flu vaccine before? ☐ **Yes** ☐ **No**
If not and less than 9 years old, it is recommended to get 2 doses of the flu vaccine this year at least 4 weeks apart.

Has the patient had a fever within the last 24 hours? ☐ **Yes** ☐ **No**
If yes, we recommend rescheduling the vaccine to a different date.

Is the patient severely allergic to eggs? ☐ **Yes** ☐ **No**

Gelatin? ☐ **Yes** ☐ **No**
If yes, we do NOT recommend getting the flu vaccine.

When they eat products that contain egg such as cakes/breads, do they have a reaction? ☐ **Yes** ☐ **No**
If yes, we recommend seeing an allergist to receive the flu vaccine.

By my signature below, I acknowledge receipt of the 2017-2018 Influenza Vaccine fact sheet. I understand the benefits and the risks of the vaccine and I am authorizing a qualified member of the Cornerstone Pediatric & Adolescent Medicine staff to administer the Influenza vaccine according to the guidelines set by the Centers for Disease Control and Prevention. *I further understand that FluMist given to a child with history of wheezing could result in increased wheezing and possible hospitalization.

Parent or Legal Guardian Signature: _____ **Relationship to Patient:** _____
(If patient is under the age of 18 the signature of a parent or legal guardian must be obtained)

Patient Signature: _____ **Date:** _____
(If 18 years of age or older)

For Office Use Only

☐ **Private Insurance** ☐ **Medicaid** ☐ **No Insurance**
☐ **Private Vaccine Given** ☐ **State Vaccine Given** *****Always use state funded vaccine for patients with Medicaid or no insurance*****

	90685 - Injectable Vaccine < 36 Months - ***Thimerosal Free***		90471 – Administration of 1 Injection
	90686 - Injectable Vaccine > 36 Months - ***Thimerosal Free***		

Nurse Signature: _____ Manufacturer Lot #: _____ Exp: _____ Site: _____