CORNERSTONE
PEDIATRIC & ADOLESCENT MEDICINE

2020-2021 Flu Vaccination Consent Form

(Please fill out one information sheet per child)

Patient's Name: _____ Date of Birth: _____

Please check appropriate boxes for the following questions:

Has this patient 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 you answered yes to either of these questions, please call the office 919.460.0993 and speak with a Triage nurse to discuss your options

Has your patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? ☐ **Yes** ☐ **No**

Has the patient ever had an adverse reaction flu vaccine or an allergy to a component of the flu vaccine in the past? *If yes, please call the office 919.460.0993 and speak with a Triage nurse to discuss your options.* ☐ **Yes** ☐ **No**

By my signature below, I acknowledge receipt of the 2020-2021 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 understand that if we are participating in the drive-through flu clinic that all occupants of the vehicle must remain in the vehicle at all times.

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

Date: _____

Email address: _____

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 – Fluarix = 6 months of age and older	☐	90471 – Administration of 1 Injection
☐	90686 – Fluzone=6 months of age and older	☐	

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