

PROVIDER _____

PEDIATRIC ASSOCIATES OF RICHMOND, INC.
QUADRIVALENT INFLUENZA VACCINE (FLUZONE – Injectable) CONSENT FORM 2017-2018

PATIENT NAME _____ DOB _____

I have either requested or been offered the influenza vaccine (“flu vaccine”) and hereby consent to have my child receive this vaccination.

I have been advised that certain adverse reactions can occur with this vaccine to include localized rash and/or soreness at the injection site, fever, fatigue, and even possibly a severe allergic reaction. My child has no severe allergy to Eggs, as this vaccine should not be given to persons with this allergy. My child has no history of Guillain-Barre Syndrome nor does he or she currently have a moderate to severe febrile illness as this vaccine should not be given to persons with this syndrome or a history of such.

I consent to the administration of the flu vaccine for prevention of influenza for my child.

I have been given a copy of the CDC’s Vaccine Information Sheet or Key Facts About the Seasonal Flu Vaccine.

I further understand that my insurance may or may not pay for this service.
If my insurance company does not cover this vaccine I agree to be responsible for its payment.

Parent’s/ Guardian’s Signature Relationship to Patient Date

First/Yearly dose Second dose

Manufacturer _____ LOT # _____

Site Given: _____ Dosage: 0.50ml 0.25ml.

Signature and Title of Administrator Date