2025-2026 Influenza Vaccine Consent Form

Patient's Name: _____ Patient's Date of Birth: _____

I want to receive the following immunization(s): □ Flu shot

The following questions will help us determine your child's eligibility to be vaccinated today:

INFLUENZA IMMUNIZATION SCREENING QUESTIONNAIRE			
1.	Is the patient moderately or severely ill (with or without fever)?	Yes ☐	No ☐
2.	Has the patient had a serious reaction to an influenza vaccine in the past?	Yes ☐	No ☐
3.	Has the patient had Guillain-Barré syndrome within 6 weeks of influenza vaccine in the past?	Yes ☐	No ☐
4.	If under the age of 9, has the patient received a flu vaccine before?	Yes ☐	No ☐ N/A ☐
5.	My child is at least 6 months of age.	Yes ☐	No ☐

PLEASE BE AWARE IF YOUR CHILD IS UNDER THE AGE OF 9 AND HAS NOT RECEIVED TWO OR MORE FLU VACCINES PRIOR TO JULY 1, 2025, THEY REQUIRE 2 FLU VACCINES ADMINSTERED 4 WEEKS APART.

Scan me

FLU Information Sheet

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked above. I have read and understand the information in the VIS(s). I understand the benefits and risks of all vaccines to be given today. I understand the benefits and risks of all vaccines to be given today. I asked that the vaccine(s) checked above be given to me or to the person named above for whom I am authorized to make this request. I fully release and discharge, Leawood Pediatrics, its affiliates, officers, directors, and employees from any liability related to the administration of these vaccines. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

Patient/Guardian Signature: _____ Date: _____

If legal guardian, print name: _____

----------FOR CLINIC USE ONLY----------

Date Booster Required (if applicable): _____

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number
Fluarix	IM	/ /	GSK	
Name and Title of Vaccine Administrator				