

## 2023-2024 Beyfortus Medication Consent Form

Patient's Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

I want my child to receive the following medication:  Beyfortus (Nirsevimab)



*Scan me*

The following questions will help us determine your child's eligibility to receive the RSV preventative antibody today:

IMMUNIZATION SCREENING QUESTIONNAIRE		
1. Is the patient younger than 8 months old?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Has the patient's biological mother received the RSV vaccine during pregnancy 14 days prior to giving birth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Is the patient moderately or severely ill (with or without fever)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Has the patient had a history of serious allergic reactions to nirsevimab or any of its components?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Has the patient been diagnosed with hemophilia or any other bleeding disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I have been offered a copy of the RSV Preventative Antibody immunization Information Statement checked above. I have read and understand the information in the immunization information statement. I understand the benefits and risks of the preventative antibody to be given today. I ask that the antibody 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 this medication.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If legal guardian, print name: \_\_\_\_\_