

2020-2021 INFLUENZA VACCINE CONSENT FORM

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

I want to receive the following immunization: Flu shot

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

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

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 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.

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, 2020, THEY REQUIRE 2 FLU VACCINES ADMINSTERED 4 WEEKS APART.

Patient/Guardian Signature: _____ Date: _____

If legal guardian, print name: _____