**CONSENT FOR INFLUENZA VACCINE**

**PEDIATRIC CONSENT – AGES 6 months and up**

I have been given a copy of the Vaccine Information Statement (VIS) and have had the opportunity to review it. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and the risks of the influenza vaccine and request this vaccine be given to me or the person named below for whom I am authorized to make this request. I understand this consent form with become part of my medical record a the Consiglio Wellness Center (CWC) and will be kept in accordance with the CWC Privacy Policies. I understand that the CWC Privacy Policy is available for my review at the CWC or at [www.consigliowellnesscenter.com](http://www.consigliowellnesscenter.com).

**Patient Information (Person to Receive Vaccine) \*Please Print\***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Last First MI Birth Date Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City State Zip Telephone # Sex: **M F**

**Please answer the following questions as it pertains to the person receiving the vaccine:**

**Fever of 100.0 or greater in the past 72 hours? Yes No**

**Allergy to eggs or neomycin? Yes No**

**Have you received any other vaccine in the past 2 weeks? If yes, what vaccine and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergy to latex, or a previous dose of flu vaccine? Yes No**

**Epilepsy or other nervous system condition? Yes No**

**History of Guillain-Barre syndrome? Yes No**

**History of severe swelling or severe pain following a previous dose of flu vaccine? Yes No**

**If answered yes to any questions, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is the person receiving this vaccine pregnant? Yes No**

**Signature** **of Patient/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

**\*\*FOR OFFICE USE ONLY\*\***

Date vaccinated: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ 2nd vaccine due Yes No Date 2nd vaccine due \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Route: Intramuscular Injection Site: Deltoid (R) or (L) Thigh (R) or (L)

Signature/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place label here for individual vial: