PATIENT FLU SHOT FORM

Pediatric Services 2020-2021 Flu Season

Please read the Influenza Vaccine information Statement, complete the following questions, sign and date in the space indicated and give the form to the Medical Assistant before they give the vaccine. Please notify us if you have any questions.

Name of person to receive immunization: _____**Date of Birth:** _____
Insurance : _____**ID #**_____ **GR#** _____
Address:_____
Who is your regular doctor? _____
Appointment date: _____

1. **In the past 10 days has this person had a fever, cough, headache, sore throat, diarrhea or loss of taste or smell?** _____
2. **In the past 14 days has this person been tested for Covid-19 or been exposed to Covid-19?** _____
3. **Is this person sick today with a fever?** _____
4. **Has this person ever had a serious reaction to a flu shot?** _____

If any "yes" answers, no flu vaccine can be given without a physician evaluation.

5. **If under age 9, have they ever had a seasonal flu vaccine in the past?** _____

If this is the first year ever receiving a flu shot then another will be needed in 4 weeks.

If you are wanting flumist today, please answer these additional questions:

1. **Does this person have a serious allergy to eggs or egg products?** _____
2. **Is your child wheezing today?** _____
3. **Does your child take aspirin?** _____

I wish to receive an immunization against influenza or to have my minor child immunized against influenza. I am accepting this immunization voluntarily and consent to the vaccine being given to me or my child. I have read the VIS sheet provided. I understand the risks and benefits of this immunization. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against Pediatric Services, PA, its members, employees, and agents on account of any injury or misfortune I may suffer as a result of this immunization.

Signature: _____

DO NOT COMPLETE BELOW THIS LINE

Immunization administered by: _____

_____ Fluzone 0.5 ml IM (3 years and older) Quadrivalent

_____ Flumist LAIV4 (2 years through 49)

_____ They ALSO received _____

_____ Vaccine documented in OP