Influenza Injection Vaccine Minor Consent Form

If available,
place patient identification sticker here

Child Name: _____ Date of Birth: _____

Does your child have allergies to medications, food, a vaccine component, or latex? ☐ Yes ☐ No

Has your child ever had a serious reaction after receiving a vaccination? ☐ Yes ☐ No

Has your child ever had Guillain-Barre syndrome? ☐ Yes ☐ No

Is the patient to be vaccinated anxious about getting vaccinated today? ☐ Yes ☐ No

If you answered yes to any of the above questions your child will not be able to receive the flu shot at this event. If you would like your child to receive an influenza vaccine, please contact your child's health care provider.

To learn more about the flu shot please visit: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

Parent/Guardian understands and consents to vaccine.

_____ _____ _____
Signature of person to receive vaccine Date Time

_____ _____ _____
Signature of Parent/Legal Guardian Date Time

_____
Print name of Parent/Legal Guardian

_____
Relationship to patient

_____
Phone number of Parent/Legal Guardian