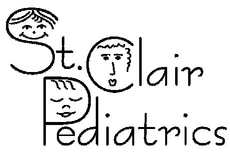

CONSENT FOR THE INFLUENZA VACCINE

I have read the information about the influenza vaccine. I have had the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make the request. I authorize St Clair Pediatrics, LLC to submit documentation for payment of this service to my insurance carrier and I agree to pay St Clair Pediatrics, LLC in the event that this service is not a covered benefit on my insurance policy.

PATIENT INFORMATION

______________________	______________________	______	______
Last Name	**First Name**	**MI**	**Age**

______________________	____________	______	______	____________
Street Address	**City**	**State**	**Zip**	**Phone**

______________________	______________________	____________
Signature of Parent or Legal Representative	**Relationship to Patient**	**Date**

Today's Health: ☐ **Good** ☐ **Other (explain):** ____

____

Is the person receiving the influenza vaccine allergic to eggs? ☐ **Yes** ☐ **No**

Is the person receiving the influenza vaccine currently receiving chemotherapy? ☐ **Yes** ☐ **No**

Has the patient received the influenza vaccine before? ☐ **Yes** ☐ **No**

Did the patient receive the H1N1 vaccine last year? ☐ **Yes** ☐ **No**

Please be advised that two doses administered at least one month apart are recommended for children ≤ 9 years of age who are receiving influenza vaccine for the first time or receiving the H1N1 vaccine for the first time.

OFFICE USE ONLY

Temperature: ____________________ ° F Time: ________________ AM PM

Office Address: 4941 Benchmark Centre Drive, Suite 100 Swansea, Illinois 62226

Date vaccine administered: ________________ Site of injection: ☐ Left ☐ Right ☐ Deltoid

Vaccine Manufacturer:

Signature of vaccine administrator: ________________________________ Title: ______________________