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**

Temperature: _____ ° F Time: _____ AM PM

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**

If 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.

OFFICE USE ONLY

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: _____