

Chart #: _____

Provider: _____

Mountain View Pediatrics

Flu Vaccine Date _____

Patient: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Mom SSN: _____ Dad SSN: _____

Please check YES or NO

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Known allergies to eggs, chicken or chicken feathers | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. History of Guillain-Barre Syndrome (GBS) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A severe reaction to any vaccine component | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Current fever | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Previous problems with flu vaccine | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does this child have any acute/chronic medical conditions such as: heart disease, diabetes, asthma, cancer, or immune system disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes, please specify: _____

CONSENT: (Please Initial Each Line)

_____ I have read or have had explained to me the information about influenza and influenza (flu) vaccine. I have the right to ask questions that will be answered to my satisfaction. I understand the benefits and risks of flu shot and ask that the flu shot be given voluntarily to me or to the person named above for whom I am authorized to make this request.

_____ I have received a copy of the CDC "Vaccine Information Statement"

_____ I acknowledge receiving Mountain View Pediatrics "Notice of Privacy Practice" statement, and understand that I have the right to review the notice prior to signing this consent form

_____ I agree that Mountain View Pediatrics shall have no responsibility or liability if I contract influenza, other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot or flu mist.

Parent/Guardian Signature: _____ Date: _____

Office use only below this line

_____ SELF PAY _____ MEDICAID _____ NC HEALTHCHOICE _____ INSURANCE

Place sticker here.

Site: _____ Given By: _____ Private or State

Flumist .50 .25

#1 dose _____ #2 dose _____