ADMINISTRATION OF THE FLU VACCINE CONSENT FORM

NAME:____DOB__________DOCTOR________________

Dear Parents, Please read the Facts About Influenza "Flu" Vaccine and answer the following questions.

1. Do you prefer the flu injection or Flu Mist (nasal spray for children 2yrs & older)? Check one A) Injection_____or B) Nasal Spray____. If you checked flu nasal spray PLEASE READ: The following people should get the flu shot instead*

   *Children younger than 5 with asthma or one or more episodes of wheezing within the past year.

   *People who have long-term health problems with:

-heart disease	-kidney or liver disease
-lung disease	-metabolic disease, such as diabetes
-asthma	-anemia and other blood disorders

   *Anyone with certain muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems.

   *Anyone with a weakened immune system

2. Has your child ever received the flu vaccine before? YES____NO____
3. Has your child received the flu vaccine in the last 6 months? YES____NO____
4. Has your child been ill or run a temperature in the last 48 hours? YES____NO____
5. Has your child ever had a allergic reaction to the influenza vaccine? YES____NO____
6. Is your child allergic to chicken eggs or have a history of Guillain-Barre Syndrome? YES____NO____
7. Is your child pregnant? YES____NO____
8. Did you read and understand the "Facts about Influenza Vaccine"? YES____NO____
9. Do you have any questions? YES____NO____

If you answered YES, Please list your question(s)________________________________

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If the parent answers YES to any questions, a physician MUST be consulted.

I hereby authorize my child to have the FLU VACCINE and authorize the physician listed on this form to release to my insurance company any information necessary to process my insurance claim with payment directly to the physician.
I understand I will be responsible for all charges denied by my insurance company.

____ ____________________
Parent Signature Date

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