

Please fill out one form for each child receiving the flu vaccine



**Seaside Pediatrics 2023-2024 Flu Vaccination Consent Form**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

**Please circle one.**

Has the patient ever had the seasonal flu vaccine before? Yes    No  
If not and less than 9 years old, it is recommended to get 2 doses of the flu vaccine this year at least one month apart.

Has the patient had a fever within the last 24 hours? Yes    No  
If yes, we recommend rescheduling the vaccine to a different date.

Is the patient allergic to eggs? Yes    No

Has the patient been diagnosed with COVID-19 within the previous 2 weeks or awaiting test results? Yes    No

Has the patient ever had a reaction to a previous dose of flu vaccine? Yes    No

Does the patient have any acute/chronic medical conditions which would cause a weakened immune system, such as asthma, diabetes, or reactive airway disease? Yes    No

Is there a chance your child already received their 2023-2024 flu vaccine at school this year? Yes    No  
You would have signed a release form that was sent home from school with your child.

***I would like my child to receive the flu vaccine injection today. By my signature below, I acknowledge receipt of the 2023-2024 Influenza Vaccine fact sheet. I understand the benefits and the risks of the vaccine, and I am authorizing a qualified member of the Seaside Pediatrics staff to administer the flu vaccine according to the guidelines set by the Centers for Disease Control and Prevention.***

Parent or Legal Guardian Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian Phone Number: \_\_\_\_\_

Date Administered:	Site of Injection:	
Vaccine Manufacturer:	Lot Number:	Expiration Date:
Administered By:	Time Administered:	

Private Vaccine Given     State Vaccine Given