AHN PEDIATRICS
Pediatric Alliance

INACTIVATED FLU VACCINE CONSENT FORM

I voluntarily submit to and authorize PEDIATRIC ALLIANCE to administer the flu vaccine to me/my child for the purpose of immunizing against influenza and have reviewed the Vaccine Information Statement. I have had a chance to ask questions and understand the information presented to me.

I understand that if this is not a covered service under my insurance, that I will be responsible for the cost.

Contraindications:

Check any of the following that apply to you:

- ☐ Severe allergies to flu vaccines in the past
- ☐ Acute respiratory illness with a fever
- ☐ A history of Guillain-Barre Syndrome or active neurological disorder
- ☐ Currently on long-term steroids
- ☐ Sensitivity to latex

I understand that occasional reactions may occur and these may include:

- Local reactions: soreness at the vaccine site
- Systemic reactions: fever, aches
- Immediate or allergic reactions: In rare cases a serious allergic reaction may occur. Signs of a serious allergic reaction may include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat or dizziness, and require immediate medical attention.

I have read the contraindications above and have discussed any concerns with my healthcare provider.

I understand that I am to report to the nearest Emergency Department if a severe reaction occurs.

Patient Name: _____ **DOB**: _____

Parent/Guardian/Patient Signature: _____

Date: _____

Site: RA_____ LA_____ RT_____ LT_____