Pediatric Associates, PSC
2865 Chancellor Drive Suite 225
Crestview Hills, KY 41017
(859-341-5400)

Please read and fill out the Flu Vaccine Consent Form:

Today's Date_____ Time_____

Child's Name: (please print)_____ DOB: _____

Does this child have Asthma or recurring wheezing? Yes No

Has this child had any episodes of wheezing in the past 12 months? Yes No

Influenza vaccination is the primary method of preventing influenza and its severe complications. (Mist or injection)

If your child has a severe allergy to eggs he/she should not receive the flu vaccine here. (Mist or injection)

If your child has a mild allergy to eggs he/she may be able to receive the flu shot. (Injection)

If your child has had a fever >101.5 in the past 24 hours he/she should not receive the flu vaccine. (Mist or injection)

If your child has received the MMR (Measles, Mumps and Rubella vaccine) or Varivax (chicken pox vaccine) in the past 30 days they must wait a full 30 days before receiving the Flu Mist. (Mist only)

SIDE EFFECTS: Soreness around the injection site that can last up to 2 days. (Injection only) Fever, malaise (vague feeling of discomfort), myalgia (body aches or muscle pain) which can start 6-12 hours after the injection and can last up to 2 days. (Mist or injection) Runny nose (Mist only).

I have read the flu information and give my permission for my child to receive the flu vaccine.

Parent signature:_____

FOR STAFF USE ONLY:

Dose: _____0.5ml _____0.25ml _____ mist Lot #: _____

Site: _____Lt deltoid _____Rt deltoid _____RAT _____LAT _____RLT _____LLT

Administered by: _____ CHARTED BY:_____