CHILDREN'S MEDICAL CENTER

NON-PATIENT CONSENT FOR TREATMENT
INFLUENZA SHOTS 2024-2025

Last Name: **First Name:** **MI:**

Date of Birth: **Age:** **Sex: Male** **Female**

Street: **City:** **State:** **Zip:**

Telephone Number:

PRECAUTIONS & CONTRAINDICATIONS:	**Please Circle**	
1. Do you have a history of hypersensitivity to chicken eggs or egg protein?	Yes	No
2. Do you have any hypersensitivity to any component of the vaccine, including thimerosal?	Yes	No
3. Do you have a history of Guillain-Barre syndrome?	Yes	No
4. Do you currently have a fever, respiratory illness or any other type of infection?	Yes	No
5. Have you ever had a bad reaction to another vaccine:	Yes	No

Please list the adverse reaction: ____

Allergy:____

If you have answered "YES" to any of the above questions, please consult your personal physician for administration of the flu vaccine.

Note: Because pregnancy increases the risk of complications and hospitalization from influenza, women who will be pregnant during influenza season should receive influenza vaccination during the autumn months.

I have read/had explained to me the information about influenza as well as information regarding the influenza vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that Children's Medical Center shall have no responsibility or liability if I contract influenza, pneumonia, other respiratory diseases, or suffer any other adverse reaction following administration of the flu shot. I have read the Vaccine Information Sheet for influenza vaccine.

Signature of Responsible Party: ______________________________ ***Date:*** _______________

Check the Box Below for Lot # used.

☐ **Fluzone Sanofi Pasteur – Lot # U8435AA – Exp. 06/30/2025**

Nurse/MA: _______________ **Site: L R**