INFLUENZA VACCINE CONSENT FORM

Patient Name: ____ Date of Birth: _____ / _____ / _________

VACCINE ELIGIBILITY:

Is your child less than 3 years old?	Yes	No
Is your child allergic to eggs?	Yes	No
Has your child had a serious reaction to a previous influenza vaccine?	Yes	No
Has your child ever had Guillain-Barré syndrome?	Yes	No

CONSENT:

I have read or had explained to me the Vaccine Information statement for the seasonal influenza vaccine and understand the risks and benefits. Not all insurance companies cover influenza vaccines. As a courtesy, we will bill your insurance company, however, if this is not a covered benefit, you agree to pay Stepping Stones Pediatric and Adolescent Medicine $40.00 for the injectable quadrivalent vaccine.

____ _____ / _____ / _________
Signature of Parent or Legal Guardian Date

INFLUENZA VACCINE CONSENT FORM

Patient Name: ____ Date of Birth: _____ / _____ / _________

VACCINE ELIGIBILITY:

Is your child less than 3 years old?	Yes	No
Is your child allergic to eggs?	Yes	No
Has your child had a serious reaction to a previous influenza vaccine?	Yes	No
Has your child ever had Guillain-Barré syndrome?	Yes	No

CONSENT:

I have read or had explained to me the Vaccine Information statement for the seasonal influenza vaccine and understand the risks and benefits. Not all insurance companies cover influenza vaccines. As a courtesy, we will bill your insurance company, however, if this is not a covered benefit, you agree to pay Stepping Stones Pediatric and Adolescent Medicine $40.00 for the injectable quadrivalent vaccine.

____ _____ / _____ / _________
Signature of Parent or Legal Guardian Date