INFLUENZA VACCINE

Please read the corresponding CDC information regarding influenza vaccine. Then complete the questionnaire below.

I want my child (the patient) or myself to receive:

____ Inactivated influenza (injectable) vaccine

Please sign below indicating that:

____I (patient/parent/guardian) am in good health with no acute illnesses.

____I (patient/parent/guardian) have read the Vaccine Information Sheet for the Influenza Vaccine which is posted on the MPG website. (Please ask our staff if you would like a paper copy.)

____I (patient/parent/guardian) understand the risks and benefits of the vaccine and have had a chance to ask questions.

____I (patient/parent/guardian) have not ever had a serious reaction to a previous dose of the flu vaccine.

____I (patient/parent/guardian) have not ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine.

By signing below, I give consent to the Maryland Pediatric Group and its staff for my child/myself named at the bottom of this form to be vaccinated with this vaccine.

MPG Provider: _____

Patient Name: _____Patient DOB:_____

Patient/Parent/Guardian Signature: _____Date: _____

Print Name: _____

For Office Use Only: **Staff Initials _____** **Vaccine Site _____**

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