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: _____

If your child has a severe allergy (anaphylaxis) to eggs he/she should not receive the flu vaccine here. Please consult with your allergist.

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

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

SIDE EFFECTS: Soreness around the injection site that can last up to 2 days. 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.

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 Lot #: _____

Site: _____Lt deltoid _____Rt deltoid _____RAT _____LAT _____RLT _____LLT

Administered by: _____ CHARTED BY:_____