larchmont pediatrics
pediatric and adolescent medicine

Flu Shot Vaccine Registration and Consent to Administer Flu Vaccine

Name of Person Receiving Vaccine_____ Date _____

Date of Birth _____

Telephone Number _____

Home Address _____

Primary Care Physicians Name & Phone Number _____
(If other than Larchmont Pediatrics)

Please read the following and indicate "yes" or "no" for the person receiving the vaccine today:

1. Have you ever had a severe reaction to a flu vaccine? Yes No
2. Have you ever fainted or felt dizzy after receiving a flu vaccine? Yes No
3. Have you had fever, diarrhea, vomiting or any other cold symptoms in the last 48 hours? Yes No
4. Do you have a history of Guillian-Barre Syndrome? (Autoimmune condition caused by a virus or bacteria that causes muscle weakness and/or paralysis) Yes No
5. Are you being treated with chemotherapy or radiation for cancer, have HIV/AIDS or any immunodeficiency disorder or are immunocompromised? Yes No

I have read or have had explained to me, information about the flu vaccine. I have had a chance to ask questions that were answered to my satisfaction. 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 have been given a copy of the Vaccine Information Statement.

Printed Name of Person Giving Consent _____

Relationship to Patient_____

Signature_____ Date _____

Flucelvax _____ left/right - arm/thigh _____
Lot # Site of Injection Administered By

Charges

Each dose of the flu vaccine is $70.00

We will bill your insurance as a courtesy, if your insurance does not cover the charge, you will be responsible for payment, we will send you a bill.

Dosing

Children, adolescents and adults, age 9 and older will only require 1 dose regardless of whether they have been previously vaccinated. Children 8yrs and under, if receiving their first flu vaccine, will require 2 doses, at least 30 days apart.

Side Effects of the flu vaccine

The most common side effects are soreness at the injection site; tenderness, pain and swelling. Slight fever, headache, irritability, sleeplessness and malaise.

*****If you have any adverse or possible allergic reactions, (such as hives, pain, swelling, itching or burning) contact your primary care physician immediately or if severe, call 911*****

I have read and understand the above information and have had the chance to ask questions that were answered to my satisfaction

_____ _____

Signature Date