DATE_____

Centennial Valley Pediatrics

Consent for Treatment

****

Name of person receiving Injection_____ Age_____

Date of birth_____ Insurance Name_____

The following questions will help us determine if your child should not receive the Enflonsia injection. If you answer "YES" to any question it does not mean that you should not be vaccinated, it means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is your child sick today? Yes_____ No_____
2. Has your child ever had a serious reaction to an injection in the past? Yes_____ No_____
3. Does your child have a known bleeding disorder? Yes_____ No_____
4. Is your child on an anticoagulant medication? Yes_____ No_____
5. Did the mom of this patient receive the RSV vaccine during the third trimester of pregnancy? If yes, was it more than 14 days prior to delivery?

I have read the above information about Enflonsia and truthfully answered all questions. I have had a chance to ask questions and fully understand the benefits and risks of Enflonsia. I agree that Centennial Valley Pediatrics shall have no responsibility or liability if I suffer any other adverse reaction following the administration of Enflonsia.
I have received a copy of the Immunization Information Statement (09/25/2023)

Signature:_____ Date:_____

Please fill in Patient Name and Date of Birth on backside of form.

Patient Name:_____ Date of Birth:_____

Date Immunization and IIS given:_____

Immunization Information Statement: 9/25/2023

Enflonsia 0.7mL Lot:_____ Exp:_____ Site:_____

Given By: (initial) _____