

# Flu Vaccine Request Form

Please complete this form in its entirety if you would like your child to receive a Flu Vaccine. Every field is required unless explicitly stated as "Optional". Incomplete forms cannot be processed and will not be accepted. One form per child receiving the vaccine.

## Patient Information:

Patient's Full Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ ZIP: \_\_\_\_\_  
Primary Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

## Risks and Possible Side Effects:

Side effects of the influenza vaccine are generally mild in children and are uncommon. These reactions include tenderness around the injection site, fever, chills, headaches, or muscular aches. These symptoms can last up to 48 hours.

## Acknowledgement of Risk: Initial Each Statement

\_\_\_\_ I hereby voluntarily consent to allowing my child listed above to receive an injection of the Influenza Vaccine. (Intramuscular injection of the Influenza Virus Vaccine. Trivalent Types A and B)

\_\_\_\_ I have been made aware of certain risks and consequences that are associated with a flu vaccine.

\_\_\_\_ I hereby release the office of Jeth V. Salomon, M.D. from any and all legal liability for the injection of the flu vaccine for my child listed above.

\_\_\_\_ I understand that I will be fully responsible for the cost of the vaccine if for any reason my child does not get the vaccine.

## Vaccine Readiness: Answer all questions as accurately as possible

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Does your child have an egg allergy?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your child currently receiving allergy shots?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of Guillian-Barre Syndrome?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your child previously received the flu vaccine?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your child covered by a full Medicaid plan? (NOT HealthyKids or MediKids) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does your child use a health-share program or self-pay?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

## Parent/Guardian Consent:

Name of Parent/Guardian: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

*If requesting a vaccine for yourself, list your name and list relation as "self"*

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

This form may be submitted by sending it to our office by Fax (727-344-0632) or Email (office@salomonpediatrics.com), or by delivering the completed form to the front desk in-person. After vaccines are received, all patients that have requested forms will be contacted by phone to create appointments to receive the vaccine. Submitting your form before June 30<sup>th</sup> guarantees availability for your vaccine.

Office Use only:

Date Received:

Pre-Order or Post Order:

Date of Appointment: