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. 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. (Intermuscular 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 before March 1st.

Vaccine Readiness: Answer all questions as accurately as possible

Does your child have an egg allergy?	☐ Yes ☐ No
Is your child currently receiving allergy shots?	☐ Yes ☐ No
Do you have a history of Guillian-Barre Syndrome?	☐ Yes ☐ No
Has your child previously received the flu vaccine?	☐ Yes ☐ No
Is your child covered by a full Medicaid plan? (NOT HealthyKids or MediKids)	☐ Yes ☐ No
Does your child use a health-share program or self-pay?	☐ Yes ☐ 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: ___/___/_____

The authorization provided by this form is valid until March 1st of the year following the date this form is completed. This form may be submitted by sending it to our office by Fax (727-344-0632), our Secure Inbox (sendsafe.to/office@salomonpediatrics.com), or by delivering the completed form to the front desk in-person. After vaccines are received, all patients that have requested vaccines will be contacted by phone to create appointments to receive the vaccine. Each family will be contacted once to make their appointment. Submitting your form before June 30th guarantees availability for your vaccine.

Office Use Only:

Date Received: *Ordered before June 30th:* *Appointment Date:*