Shawnee Mission Pediatrics
An Affiliate of Children's Mercy

FLU VACCINE CONSENT

I have read or had explained to me information about the flu vaccine. I understand the benefits and risks of the vaccine and ask that the vaccine be given to my child, _____ - ____/____/_____.
(Patient Name) (Date of Birth)

Patient's PCP: _____

CHOOSE ONE:

____FLU SHOT, INACTIVATED

____FLUMIST, LIVE (if available)

CHECK IF TRUE:

____MY CHILD HAS BEEN FEVER-FREE FOR PAST 24 HOURS

____MY CHILD HAS NOT HAD A POSITIVE COVID TEST IN THE PAST 14 DAYS

____MY CHILD DOES NOT CURRENTLY HAVE A COVID TEST PENDING

Circle one:
Do you have any concerns about stable housing, food supply, reliable transportation, or safety at home? YES / NO

_____ _____
SIGNATURE RELATIONSHIP TO PATIENT

DATE: _____

FOR OFFICE USE ONLY

Manufacturer _____

Lot number_____

Site_____

Initials_____

Date_____