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 Pediatrician: _____

CHOOSE ONE:

____FLU SHOT, INACTIVATED (6 Months and older)

____FLUMIST, LIVE **(2 years and older)**

CHECK IF TRUE:

____MY CHILD HAS BEEN FEVER-FREE FOR THE PAST 24 HOURS

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_____