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Pediatric Vaccine Consent Form (FLU/COVID)

Parent/Guardian: Answer the following questions to help us safely give your child vaccinations (Annual Influenza/COVID)

Information for the child

Which vaccinations are you getting today? __Annual Influenza ☐ / COVID Booster – 2023 ☐

Last Name: _____ First Name: _____ Middle Initial: _____

Birthdate: _____Age: ____ Parent/ Guardian Name: _____ Relationship – Parent or Guardian.

Mailing address: _____ City_____ State____ Zip code_____

Mobile Phone Number: _____ Home/ Alternative phone number: _____

Email: _____

Allergies: _____ Chronic conditions: _____

Do you have insurance? Yes/ No. IF yes, Name of the insurance provider: _____

Cardholder's name: _____ Date of birth_____ Relationship: _____

BIN Number: _____ PCN No: _____ ID No: _____ Rx-Group No: _____

Race: Circle one - ***American Indian*** or ***Alaska Native*** or ***Asian Native*** or ***Hawaiian or Other Pacific Islander Black*** or ***African American*** or ***White*** or ***Other Race*** or ***Unknown*** or **Decline to answer**

Ethnicity: Circle one – ***Hispanic/ Latino*** or ***Non-Hispanic/non-Latino*** or ***Unknown ethnicity*** or **Decline to answer**

Sex assigned at birth _____Male/ Female.

Gender identity: Male/ Female/Transgender male/ Transgender female/ Genderqueer/non-binary/ Other/ Decline

Doctor/primary care provider name: _____Phone: _____

All Vaccines	Yes	No	Don't Know
Is the child sick today?			
Does the child have allergies to medications, food (ie. eggs), latex or any vaccine component (i.e., neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast, or yeast)?			
Has the child had a serious reaction to a vaccine in the past?			
Does the child have a long-term health problem with lung, kidney, or metabolic disease (like diabetes), asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant, or spinal fluid lead? **IF Yes – Please specify:**			
Does the child have cancer, leukemia, AIDS, or any other immune system problem?			
Does the child have a sibling or parent with an immune system problem?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (i.e. Gullain-Barre Syndrome)?			
Does the child take cortisone, prednisone, other steroids, or anticancer drugs, or had X-ray treatments?			

During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Has the child received any vaccinations or skin tests in the past 4 weeks?			
Did you bring your Immunization Record Card with you?			

Parent or Guardian signature: _____Date: _____

QR code for FLU VACCINE INFORMATION FACT SHEET.

Inactivated Influenza Vaccine Information Statement | CDC

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html

Post Vaccination Record/ For the Pharmacy Use only

Name of the vaccination provided: _____

Site of administration: _____

Lot Number: _____

Expiration Date: _____

Vaccinator's Name/ Initials: _____

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