Doctors of Children of Orange County Medical Corporation
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PEDIATRICFLU VACCINE CONSENT FORM

I have been given, read and understand the vaccine information sheet regarding the **2013-2014** influenza (flu) vaccine/mist. I have asked that this vaccine be given to my child whose name is listed below. I am authorized to make this decision.

Patient Full Name: _____Date of Birth: _____

Signature of Parent: _____Date:_____

High risk illness requiring influenza vaccine e.g. asthma, diabetes, heart disease, kidney disease (**Please circle or fill in**) _____

1.	Has the patient ever had an allergic reaction to egg or egg products?	Yes	No
2.	Has the patient been ill in the past week?	Yes	No
3.	Does the patient currently have any cold or flu symptoms?	Yes	No
4.	Do you or your child have an immunodeficiency disease?	Yes	No
5.	Could the patient be pregnant?	Yes	No
6.	Has the patient previously received the flu vaccine?	Yes	No
7.	If yes, did they experience an adverse reaction?	Yes	No
8.	Have you had Guillain-Barre syndrome?		

_____

For staff use only

Influenza vaccine Lot # ----------

Site of injection----------

Signature of administering staff ----------

Date ----------.