Arundel Pediatrics Influenza Screening

Date: ___________________________

Patient Name: ____________________

Date of Birth: ____________________

1. Is the person to be vaccinated sick today or had a fever in the last 24 hours?

   Yes **No**

2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? **Yes** **No**

3. Has the patient to be vaccinated ever had a serious reaction to influenza vaccine in the past? **Yes** **No**

4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?

   Yes **No**

Consent:

I have received and read the Vaccine Information Statement about the Influenza vaccine. I give permission for my child to receive the Influenza virus vaccine, given by the medical staff of Arundel Pediatrics. I recognize and understand that, as with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine and I assume any risk.
Some Insurance policies do not cover the flu vaccine, or the administration of flu vaccines. I agree to be personally and fully responsible for payment.

Print Name: _________________________

Signature: __________________________

Date: ______________________________