OC Pediatrics Medical Group, Inc

Flu Shot Consent Form

Please circle your response

1. Have you had a flu shot before?	Yes	No
2. Are you allergic to eggs?	Yes	No
3. Are you currently taking an antibiotic for infection?	Yes	No
4. Do you feel ill today or do you have a fever?	Yes	No
5. If you are female, are you pregnant?	Yes	No

I hereby certify that the foregoing history is true and complete to the best of my knowledge, and I request the influenza vaccine. I understand the benefits and risks of influenza vaccine, and ask that the vaccine be given to me.

Information about person to receive vaccine (please print)

Name _____ Date of Birth _____

Address _____

Signature _____

FOR CLINIC USE
Influenza:
Date Vaccinated:
Manuafacturer and Lot #:
Expiration: