PEDIATRIC HEALTH CARE ALLIANCE, P.A.

Your Child's Medical Home™

SEASONAL INFLUENZA VACCINE INFORMATION AND AUTHORIZATION

Patient Name: _____ Date of Birth: _____

I have read the Centers for Disease Control and Prevention's current year *Influenza Vaccine What You Need to Know* Vaccine Information Sheet (see attached) and understand the issues associated with the vaccine as well as contracting influenza.

	YES	NO
Is your child sick today?		
Has your child ever experienced a severe allergic reaction (e.g. wheezing, decreased blood pressure, vomiting, difficulty breathing or swallowing) to egg, or to any component of the flu vaccine?		
Has your child ever had a serious reaction to influenza vaccine in the past?		
Has your child ever had Guillain-Barre syndrome?		

I acknowledge that I have received written information about the influenza vaccine and the disease, and have had ample opportunity to have my/our questions answered by our child's pediatrician. After reviewing the influenza vaccine information provided as specified above, I authorize for Pediatric Health Care Alliance, P.A., to administer the influenza vaccine to my child.

_____

Parent/Legal Guardian Name (print) *Signature* *Today's Date*

Office Use Only: I have reviewed the above information.

_____ _____ _____

Print name of staff member *Signature of staff member* *Today's Date*