**2024-2025 Flu Vaccination Consent Form**

*(Please fill out one information sheet per child)*

**Patient’s Name: Patient’s Date of Birth:**

**(Child’s) (Child’s)**

**Has this child ever been seen by one of our Providers before?  Yes  No**

*If not, please schedule a well child check with one of our providers within two weeks of receiving flu vaccine.*

**Has the patient ever had the seasonal flu vaccine before?  Yes  No**

*If not and less than 9 years old, it is recommended to get 2 doses of the flu vaccine this year at least 4 weeks apart.*

**Has the patient had a fever within the last 24 hours?  Yes  No**

*If yes, we recommend rescheduling the vaccine to a different date.*

**Is the patient severely allergic to eggs?  Yes  No Gelatin?  Yes  No**

*If yes, please call the office 919.460.0993 and speak with a Triage nurse to discuss your options.*

**Has your child ever had Guillain-Barré Syndrome (a type of temporary severe  Yes  No**

Qr code

Description automatically generated**muscle weakness) within 6 weeks after receiving a flu vaccine?**

***By my signature below, I acknowledge access to the 2024-2025 Influenza Vaccine fact sheet QR Code (presented to the right). I understand the benefits and the risks of the vaccine, and I am authorizing a qualified member of the Cornerstone Pediatric & Adolescent Medicine staff to administer the Influenza vaccine according to the guidelines set by the Centers for Disease Control and Prevention.***

**Parent / Legal Guardian / Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(If 18 years of age or older)***

**Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(****If patient is under the age of 18 the signature of a parent or legal guardian must be obtained)***

**For Office Use Only**

**Private Insurance  Medicaid  No Insurance**

**Private Vaccine Given  State Vaccine Given *\*\*Always use state funded vaccine for patients with Medicaid or no insurance\*\****

|  |  |  |  |
| --- | --- | --- | --- |
|  | 90656 – Fluarix = 6 months of age and older |  | 90471 – Administration of 1 Injection |
|  | 90656 – Fluzone=6 months of age and older |  |  |

Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer Lot #: \_\_\_\_\_\_\_\_\_\_ Exp: \_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_