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## INFLUENZA IMMUNIZATION CONSENT & WAIVER

DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

**Consent for Immunization:**

I have received a copy of the Vaccine Information Statement for Influenza. I understand the risks of the influenza disease which this vaccine prevents. I understand the risks and benefits of receiving this vaccine. I have had a chance to ask any questions.

I am an adult who can legally consent for the person named above to get this vaccine, and I freely and voluntarily give my signed permission for this vaccine to be given.

**Waiver:**

I agree to pay for my child's Flu Shot/Flu Mist today by cash, check, or credit card during my physician's designated Flu Shot Clinic. I understand that my insurance company will not be billed for this service.

If my child requires a 2<sup>nd</sup> dose of Flu vaccine, an appointment will be made at the time the 1<sup>st</sup> dose is given, and that a 2<sup>nd</sup> dose will be held in his/her name for no more than 45 days. If we fail to keep this 2<sup>nd</sup> appointment, I understand that this dose will then be given to another child.

I also understand that in the situation of a vaccine shortage, my physician must use his/her discretion in giving any reserved doses to those that need it most.

Signature of patient or person authorized to give consent for this immunization:

Signature	Printed Name	Date
<b>FLUZONE IM inj. 0.25 ml</b> <b>FLUZONE IM inj. 0.5 ml</b> <b>Flumist intr.</b> <b>1<sup>st</sup> DOSE</b> <b>2<sup>nd</sup> DOSE</b>	<b>Y N HX OF G-B SYNDROME</b> <b>Y N ALLERGY TO CHICKEN</b> <b>FEATHERS/EGGS</b> <b>Y N HX OF SEIZURES</b>	

Physician's Signature	Date
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