**North Atlanta Pediatrics**

***Influenza Shot Form for Patients***

1. **Please Print**
2. **Complete all areas of form**
3. **Signature required at bottom of Form**

**This Box for Office Use Only:**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu Vaccine Paid by \_\_\_Cash \_\_\_ Credit Card \_\_\_ Check \_\_\_\_\_\_\_\_ Check #

Amt Paid \_\_\_\_\_\_\_\_\_\_ Child’s Acct # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Appt Date: |
| First Name | Last Name | Middle |
| Age | Date of Birth | \_\_\_Male\_\_\_Female |

|  |  |  |
| --- | --- | --- |
| Please check appropriate box: | Yes | No |
| 1 | Does your child have an egg allergy?If **Yes**  was it Hives \_\_\_\_\_\_ or Anaphylactic reaction \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 2 | Is your child currently ill or running a fever? |  |  |
| 3 | Does your child have a history of Guillain-Barre Syndrome (GBS)? |  |  |
| 4 | Has your child ever had a serious reaction to a previous vaccination? |  |  |
| Explain any yes answers on questions 1 through 4: |

***If your child is under 9 years check with your health care provider to see if you need a second dose.***

***The interval between doses must be at least 4 weeks.***

I have read the Vaccine Information Statement which includes the indications, precautions, possible adverse reactions or complications related to the vaccine. I hereby consent to and authorize North Atlanta Pediatrics to administer this vaccine.

I hereby release North Atlanta Pediatrics and its employees from any and all liabilities in connection with this vaccine and its administration to me.

**Signature of parent consenting to the vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To be completed by nurse administering the vaccine:**

* All yes answers have been addressed
* Vaccine and lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Location given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Data has been put into GRITS (Must be added manually – Add patient as needed)
* Nurse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_