PARKER PEDIATRICS AND ADOLESCENTS, P.C.
NON-PATIENT / ADULT CONSENT FOR TREATMENT
2023-2024 INFLUENZA SHOT VACCINE

Influenza (or "flu") is a viral infection of the nose, throat, bronchial tubes and lungs, usually occurring from November to April. The flu causes fever, chills, cough, soreness and aching in the back, arms and legs.

Different viruses cause Influenza and since viruses undergo change, new vaccines are always needed. This year's flu shot contains strains of influenza which are most likely to occur this winter. The vaccine will not protect all persons against the flu or against other illnesses that resemble the flu. It is recommended that women who will be pregnant during the influenza season should be vaccinated.

The most frequent side effect is soreness around the vaccination site for 1 or 2 days. Infrequently, fever, malaise and muscle aches may occur 6 to 12 hours after the shot and may last 1 to 2 days. As is the case with most drugs or vaccines, there is a possibility that allergic or more serious reactions could occur.

Please answer the following questions:		**Please Circle**	
1	Have you ever had a flu shot before?	☐ Yes	☐ No
2	Do you have a history of hypersensitivity to chicken, eggs, or egg protein?	☐ Yes	☐ No
3	Do you have any known hypersensitivity to any component of the vaccine?	☐ Yes	☐ No
4	Do you have any history of Guillian-Barre Syndrome?	☐ Yes	☐ No
5	Do you currently have a fever or feel moderately ill?	☐ Yes	☐ No

I have read the information about influenza and the vaccine. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me. If I have any questions, I understand that I can ask them before the vaccine is given. I agree that Parker Pediatrics and Adolescents, P.C., shall have no responsibility or liability if I contract influenza, pneumonia, other respiratory diseases, or suffer any other adverse reaction following the administration of the flu shot.

Payments of $35.00 must be made at the time of service.
INSURANCE WILL NOT BE BILLED.

Please print:			
Last Name:		First Name:	
Address:			
Phone:			
Signature		Date:	

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Lot #	Exp Date:	Site: LA RA	Nurse/MA:

Amount Paid	$	
☐ Cash	☐ Check #	☐ CC Exp: Auth #: