WILDFLOWER PEDIATRICS

Vaccination Consent

Date: _____

Patient's Name:_____

AGE: _____ DOB: _____

Please answer the following questions prior to vaccination(s).

1. Will this be the patient's **first** flu vaccine? _____
   **If yes, the patient may need a second dose 1 month after first dose.
2. Is the person to be vaccinated sick today? _____
3. Does the patient have egg allergies? _____
4. Does the patient take anticoagulant medications? _____
5. Has the patient received a blood transfusion, blood products, or been given a medicine called immune (gamma) globulin in the past year? _____
6. Has the patient taken any cortisone, prednisone, other steroids, or anticancer drugs, or had radiation x-ray treatments in the past 3 months? _____
7. Has the patient ever been diagnosed with Guillain-Barre Syndrome (an illness with sudden muscle weakness and loss of sensation in the fingers and toes)? _____

Patient or Guardian's Signature: _____