

**ASHBURN PEDIATRICS  
FLU VACCINE CONSENT**

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

I have read and understand the information on the Influenza Vaccine Information sheet (VIS). I give permission for my child to receive the vaccine.

---

1. Does your child have a history of Guillain-Barre Syndrome?    \_\_\_ Yes    \_\_\_ No
2. Has your child had an allergy shot in the last 48 hours?    \_\_\_ Yes    \_\_\_ No
3. I have received the CDC Vaccine Information    \_\_\_ Yes    \_\_\_ No

Statement.

---

I have completely read and understand and agree with the statements on this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

To be filled out by practice

---

Reviewed by nurse \_\_\_\_\_ Date \_\_\_\_\_

Lot No. \_\_\_\_\_ Expiration Date \_\_\_\_\_

Flucelvax/Fluarix (Injectable)    Site: LA    RA    LL    RL

ECW     VIIS