Williamsville Pediatrics

Influenza Vaccine Consent

Information about the Patient to receive the Influenza vaccine (please print)

Patient name_____

Date of Birth_____

Age_____

Please circle Yes or No for each question:

Has there been any illness or fever in the last 48 hours?	Yes	No
Has there ever been any serious reaction to the influenza vaccine?	Yes	No
Is there a history of Guillain-Barre Syndrome (GBS?)	Yes	No

I GIVE CONSENT to Williamsville Pediatrics for the patient named above to receive the influenza vaccine. I acknowledge that the patient and medical information provided above is correct. I have been given a copy of the Vaccine Information Statement for the Influenza Vaccine and the Notice of Privacy Policy form. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the Influenza Vaccine that will be given to the patient that I am authorized to represent. I understand that participation and receipt of the Influenza Vaccine through this office is completely voluntary. By signing below, I give my permission for the patient listed above to receive the injectable Influenza Vaccine.

Signature of Parent/Legal Guardian_____

Printed name_____**Date:**_____

COVID QUESTIONNARE AND TEMP DONE UPON ARRIVAL_____