Surf Pediatrics and Medicine

Patient:_____DOB:_____

Please check YES or NO Does the patient have:	YES	NO
1. Any serious allergies to eggs?	❑	❑
2. Any history of Guillain-Barre Syndrome (GBS)?	❑	❑
3. Any past severe reaction to any vaccine component?	❑	❑
4. Are you currently sick with a fever?	❑	❑
5. Any previous reactions to the flu vaccine which required medical attention?	❑	❑

Please note that pediatric patients 6 months to 8 years must receive 2 doses, 30 days apart, if they have NEVER received a flu vaccine in a previous year. Any questions, please speak with the nurse that will be giving the vaccine.

I have read or have had explained to me the information provided about influenza and influenza vaccine. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to sign.

Patient/Parent/Guardian Signature: _____Date:_____

Office use only below this line

____ Self Pay Child/State _____Medicaid/State Under 19

_____NC Healthchoice/Private _____Insurance/Private

_____ Self Pay Adult 19 and above/ Private Collect $35.00

.25 PFS .50 PFS MDV High Dose 65+

Lot #_____ Exp:_____ Site:_____ Given By:_____