pediatrics west, p.c.

health care for the growing years

3555 Lutheran Pkwy.
Suite 200
Wheat Ridge, CO 80033
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Fax: 303-467-0525

Medical Records/Referrals
Fax: 303-431-1038

13402 West Coal Mine Ave.
Suite 200
Littleton, CO 80127
Phone: 303-973-9300
Fax: 303-973-9308

INFLUENZA (FLU) VACCINE CONSENT FORM

I have asked questions that were answered to my satisfaction. I have read the information and understand the benefits and risks of influenza vaccine. I have asked that the vaccine is given to me or to the person named below for whom I am authorized to make this request.

PERSON TO RECEIVE VACCINE

_____ _____ _____ _____

Name (please print) Birthdate Age Phone Number

_____

Address: Street City State Zip Code

Have you ever had a reaction to an influenza vaccine? ☐ No ☐ Yes

Other allergies? _____

Are you pregnant? ☐ No ☐ Yes If Yes, Due Date: _____

Have you had a fever in the last 24 hrs. or any active signs of illness or infection? ☐ No ☐ Yes

_____

Signature (person receiving vaccine or Parent/Guardian)

For clinic use only: **PEDIATRICS WEST, P.C.** Doctor: SN NB SFE CF LA ES

_____ _____ ☐ 0.5 ml ☐ 0.25 ml

Date of Vaccination Pt. temperature

_____ Site of injection: ☐ L ☐ R ☐ Deltoid ☐ Thigh

Manufacturer and Lot No.

Signature of Staff Admininstering Vaccine: _____