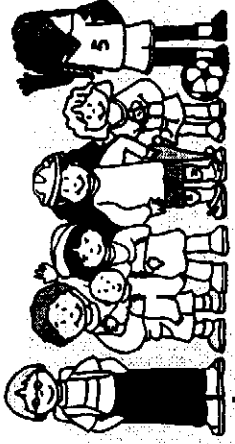


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**INFLUENZA (FLU) VACCINE
 CONSENT FORM**

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 No. _____
 Address _____ Street _____ City _____ State _____ Zip _____
 Do you have any allergies to eggs? Yes No Other allergies? _____
 Pregnant? No Yes Due Date: _____
 Do you have any active signs of illness of infection? Yes No
 Signature (Person receiving vaccine or Parent / Guardian) _____

For Clinic Use Only

PEDIATRICS WEST, P.C.

Doctor:

RCM NB SFE
 SN CF MB

Date of Vaccination _____

Manufacturer and Lot No. _____

Pt. Temperature _____

L R Deltoid Thigh
 Site of Injection _____

Signature of Staff Administering _____