



Pediatrics West, PC

Influenza Vaccine Form

“I have read, or have had explained to me, information about the influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine cited, and ask that the influenza vaccine be given to me or to the person named above (for whom I am authorized to make this request).”

Person To Receive Vaccine

Name (please print) _____ Birthdate: _____ Age: _____

Allergies: _____ Phone #: _____

Signature (person receiving vaccine or Parent/Guardian): _____

Date of Vaccine: _____ Temp: _____

Manufacturer: Sanofi Pasteur Lot # _____

Expiration Date: 6/30/2020 Dose: 0.5mL

Site: L / R Deltoid / Thigh

Signature of Staff Administrator: _____

PCP: SN / NB / SFE / CF / LA / ES