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INFLUENZA (FLU) VACCINE CONSENT 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 the person named below, for whom I am authorized to make this request.

Person Receiving Vaccine

Name (please print) Birth Date Age Phone Number

Allergies? _____

Signature (person receiving vaccine or Parent/Guardian)

For clinic use only: Pediatrics West, P.C. PCP: LA NB CF SFE SN ES

Date of vaccine _____ Temp _____

Manufacturer: Sanofi Pasteur Lot # _____

Dose: 0.5 ml Site: L / R Deltoid / Thigh

Signature of Staff Administrator _____