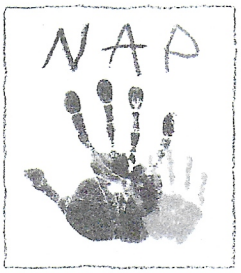


David Dobkin, M.D. ★ Beth S. Walsh, M.D. ★ Timothy Geleske, M.D. ★ Kristen Brown, M.D.
Andrew Peters, M.D. ★ Michele Lawhun, M.D. ★ Nan Walicki, M.D. ★ Suzanne Alfano, M.D.

**FLU VACCINE CONSENT**

Family Name: _____ Date: _____

Name of children receiving the flu vaccine TODAY ONLY

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

Please check if any of the following apply to your children:

1. _____ Has been ill or running a fever in the past 72 hours
2. _____ Has had a severe reaction to the flu vaccine in the past
3. _____ Has had a severe reaction to any vaccine in the past
4. _____ Has a severe allergy to eggs

Your child will need a 2nd flu vaccine this year if he or she is under the age of 9 and this is the first year of receiving the flu vaccine. The recommended minimal interval between vaccines is 4 weeks.

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I have received the Vaccine Information Statement which includes information regarding side effects.

Parent/Guardian Signature _____

RN Initials _____

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