Chattahoochee Pediatrics
~Caring for the Whole Child~

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ADULT FLU VACCINE CONSENT

Patient name _____ DOB _____ MR#_____
Insurance _____ID# _____Emergency Contact_____

Please check the appropriate answer

	Yes	No
1. Are you sick today?		
2. Do you have allergies to medications, foods, any vaccine components, or latex?		
3. Have you had a serious reaction to a vaccine in the past?		
4. Have you ever had Guillain-Barré Syndrome?		

Additional questions if you want Flumist (ages 2-49)

5. Do you have a health problem with lung, heart, kidney or metabolic disease (ex: diabetes), asthma, or a blood disorder? Is he or she on long-term aspirin therapy?		
6. Have you had wheezing or asthma in the past 12 months?		
7. Do you or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?		
8. In the past 3 months, have you taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or had radiation treatments?		
9. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
10. Are you pregnant or could become pregnant during the next 6 months?		
11. Have you received vaccinations in the past 4 weeks?		

*Please explain any yes answers*_____

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The Vaccine Information Statement for Inactivated Flu vaccine is available upon request. It is also available online at https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf. I have been given the opportunity to ask questions, and they were answered to my satisfaction. I understand the risks and benefits of the vaccines. I give consent for the vaccines checked below to be administered. I also give consent for the immunization information to be submitted to the Georgia Immunization Transaction Registry (GRITS).

I hereby give my consent to the healthcare provider of Chattahoochee Pediatrics to administer the vaccine I have requested above. I authorize the release of any information necessary for the filing of insurance claims and authorize payment from my insurance company to be sent directly to Vaishali B Kute, MD, LLC dba Chattahoochee Pediatrics. I understand that unless a preexisting agreement exists between my insurance company and this office, I will be responsible for any unpaid balance not covered by insurance. Vaishali B. Kute, MD LLC has prepared a detailed NOTICE OF PRIVACY PRACTICES to help me better understand how health information is used and shared.

- ☐ I would like the Flu shot today
- ☐ I would like the Flumist today

Patient Signature _____ Date_____

Nurse/Doctor Witness _____ Date_____