Northeast Pediatrics and Adolescent Medicine
Seasonal Influenza Vaccination Consent

FLU VACCINE IS FOR CHILDREN 6 MONTHS AND OLDER

Information about Child to Receive Vaccine (please print)

Patient Name (Last)	(First)	(M.I.)	**Patient Date of Birth** **Month_____Day_____Year _____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**Patient Age**	**Primary Insurance:**

- **All children aged 6 months-8 years who receive a seasonal influenza vaccine for the first time should be administered 2 doses.**

Consent for injectable influenza vaccine **Children 6 months and older may receive Flu Vaccine**

Injectable Flu Vaccine Consent: *I have read or had explained to me the Vaccine Information Statement for the Influenza vaccine (injectable) and understand the risks and benefits.*
I give consent to Northeast Pediatrics and Adolescent Medicine and its staff to administer to my child the ***Influenza Vaccine by injection.*** *Parent/Guardian Signature: _____ Date: _____*

Mother's Maiden Name (required for NYS vaccine registry): _____

FOR OFFICE USE ONLY

Left Right Initials_____