PEDIATRIC ASSOCIATES OF OCALA
2725 S.E. Maricamp Road
Ocala, FL 34471
Return prior to your appointment at office@paocala.com or via fax at 352-369-8703

INFLUENZA VACCINE QUESTIONNAIRE AND CONSENT FORM

Appointment Date:_____

Patient's Name:_____ Date of Birth:_____

I have read the information supplied in regards to the vaccine my child will receive at their appointment. I will be given the opportunity to ask any questions I may have and understand any risks involved.

I consent to have the influenza vaccine given to my child by Pediatric Associates of Ocala.

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For patients to be vaccinated: the following questions will help us determine if there is any reason we should not give your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. Additional questions are asked to ensure the health of your child prior to receiving their vaccination. ***Please let the nurse know if your child has had a fever and/or symptoms of illness within 48 hours of their scheduled appointment date.***

	Yes	No	Don't Know
1. Is the patient to be vaccinated sick today?	☐	☐	☐
2. Does the patient to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the patient to be vaccinated ever had a serious reaction to Influenza vaccine in the past?	☐	☐	☐
4. Has the patient to be vaccinated ever had Guillain-Barre' syndrome?	☐	☐	☐
5. Has the patient to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
6. Is the patient to be vaccinated anxious about getting a shot today?	☐	☐	☐

Consent / Form Completed By:_____ Date:_____

(Signature of Patient or Patient's Legal Guardian)

Consent / Form Reviewed By:_____ Date:_____