Tracy Hoos, DO
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Hoos Pediatrics
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INFLUENZA VACCINE CONSENT FORM

VFC/Private

Dr. Hoos J. Denton (please circle one)

1. Have you ever had a strong reaction to the Influenza Vaccine? yes or no
2. Do you have a severe allergy to eggs? yes or no
3. Have you ever had Guillian-Barre syndrome within 6 weeks of receiving the influenza vaccine? yes or no
4. Do you have a fever today or moderate to severe illness? yes or no
5. Are you 55 years of age or older (requires a higher dose)? yes or no

I attest that I have been provided the 2021-2022 vaccine information statement regarding the influenza vaccine, I understand the risk and benefits of the activated Influenza vaccine. I understand that by receiving the vaccine by the employees of Hoos Pediatric, while not a patient of the practice, in no way constitutes a physician-patient relationship between myself and the physician providers of Hoos Pediatric. I understand that there may be side effects of the vaccination and I will not hold Hoos Pediatric, nor its employees responsible for any reaction that may occur.

Name (first,middle, last) ____

Date of Birth ______________________

Street Address ____

Phone Number ____

Race (Circle) **White** **African American** **Asain** **Native American / Alaska**

Hispanic **Other** **Prefer Not to Answer**

Signature ______________________________________

.... **For Office Use Only** ....

Administered by ________ Lot # ________ Expiration Date ________ Site ________

Date Given ________ Chart # ________ OSIIS ________