7757 W Deer Valley Road, Suite 275 • Peoria, AZ 85382
Phone 623-878-2800 • Fax 623-878-9150

INFLUENZA VACCINE CONSENT FORM

Patients under 9 years of age who are receiving the flu vaccine for the first time will require a booster in 30 days.

I hereby certify that I have received and read the "Vaccine Information Statement" from the CDC, have had an opportunity to ask questions that were answered to my satisfaction, and do wish to receive the flu vaccination fully understanding the risks and the benefits. I hereby consent to the administration of the flu vaccine.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Parent/Legal Guardian Signature: _____ __ Date**:** _____

In Office Use (circle one)
Administered by: Rhonda, M.A. Anita, M.A. Denata, M.A. Gale, M.A. Sharlene, M.A.