Riverside Pediatric Associates
2024 Flu Clinic

Please print and complete before arriving in order to receive a flu shot.

2024 Injectable Influenza Vaccination

Patient First Name _____Patient Last Name_____

DOB _____/_____/_____

Parent/Guardian contact phone number: _(_____)_____-_____

- o Please arrive at exact scheduled time
- o Do not get out of the car.
- o Children – come in shorts & appropriate length sleeves - short sleeves/tank tops

The following questions will help us determine if you can get the ***2024 Seasonal Influenza Vaccine.*** Please mark YES or NO for each question. If you answer "YES" to one or more of the following questions you may not be able to receive the ***2024 Influenza Vaccine***.

1. Is the person to be vaccinated sick today?	**YES**	**NO**
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	**YES**	**NO**
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	**YES**	**NO**
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	**YES**	**NO**

If patient is a minor & you are not the parent/guardian of the child, we need a written note from the parent/guardian to administer the Flu Vaccine.

_____ _____ Date_____

Form Completed by – PLEASE PRINT **Signature of Patient or Parent/Guardian**

FOR OFFICE USE ONLY

INFLUENZA VACCINE LOT # _____

ADMINISTERED (IM) Left Arm Rt Arm / Left Thigh Rt Thigh DOSE: 0.50

Given by _____
(Please print - first initial, last name, title)