



Olentangy Pediatrics, Inc.

Eileen M. Maher, M.D. S. Randall Brown, M.D. Irene P. Koesters, M.D. Autumn M. O'Brien, M.D. Emily T. Ferguson, M.D.
Mitchell R. Camp, M.D. Jacqueline Nicodemo, M.D. Rachel Pratt, M.D. Claire S. Ackerman, Ph.D. Heather K. Guthrie, Ph.D.

I, _____ AUTHORIZE THE 2025-2026 INFLUENZA VACCINE TO BE ADMINISTERED TO:

PATIENT NAME:

PATIENT DOB:

Flu vaccine questions:

- Does the patient have a severe egg allergy (angiodema anaphylaxis)? YES or NO
- Does the patient currently have a severe illness or is currently wheezing? YES or NO
- Has the patient had Guillain- Barré Syndrome? YES or NO
- Has the patient had a severe reaction to a previous influenza vaccine (shock, anaphylaxis)? YES or NO

If yes, which patient? _____

Additional Flumist Questions:

- Is the patient older than 2 years of age? Yes or No
- Is the patient taking chronic daily aspirin/salicylates? Yes or No
- Is the patient immunocompromised or live with an immunocompromised family member? Yes or No
- Has the patient had a live vaccine (MMR or Varivax) within 4 weeks? Yes or No
- Does the patient have severe asthma or is actively wheezing? Yes or No

If yes, which patient? _____

I have been given a copy, read or have had explained to me, the information contained in the vaccine information Statement(s). I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the influenza vaccine be given to the person(s) named above, for whom I am authorized to make this request. My signature signifies my consent to the vaccine given on the corresponding date.

Signature Date

Administered by: _____