Olentangy Pediatrics, Inc.

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I, _____ AUTHORIZE THE 2026-2027 INFLUENZA VACCINE TO BE ADMINSTERED 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: _____

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