



Brookline Pediatrics
 Boston Children's
 Primary Care Alliance

We are happy to be able to offer influenza vaccination to the parents of our patients. The cost for this service is \$40, payable at the time of the vaccination.

Please complete the following:

Name of Individual to be Immunized _____

Address _____ City _____ Zip _____

Phone # _____

Date of Birth _____

Please answer the following questions:

- | | | | |
|--|-----|----|---------|
| 1. Are you sick or do you have a high fever today? | Yes | No | Unknown |
| 2. Have you ever had an allergic reaction to a flu shot? | Yes | No | Unknown |
| 3. Has the patient ever had a serious reaction to the influenza vaccine (including Guillain Barre Syndrome within 6 weeks of the vaccine administration)?? | Yes | No | Unknown |

Acknowledgement:

1. I am at least 18 years of age. I have read or had explained to me the CDC Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. I have been given the opportunity to ask questions regarding the influenza vaccine, including the risks and benefits of receiving the influenza vaccine. I understand the benefits and risks of the influenza vaccine and request that it be given to me.

 Signature of Recipient of the Vaccination

 Date

Payment Cash Check Venmo

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route/ Location	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza	↑ IM	/ /			