HUDSON HEIGHTS PEDIATRICS PARENT VACCINE CONSENT FORM

A. DEMOGRAPHIC INFORMATION

Last Name: ______________________ Date of Birth ____/____/____

First Name: ______________________ Gender: ______________________

CHILD'S NAME ______________________ Email: ______________________

(HHP Patient) ______________________ **Relationship to Active HHP Patient:**

Address: (if different from HHP Patient) ______________________ ______________________

incl. Apt# ______________________ Cell Phone # ______________________

City ______________________ Phone #2 ______________________

Zip Code ____________ State ____________ ______________________

B. HEALTH INFORMATION & MEDICAL HISTORY

VACCINE REQUESTED TODAY: (Circle those that apply)	**TDAP**	**FLU**
Have you had an allergic reaction after a previous dose of any vaccine that protects against influenza , tetanus, diphtheria, or pertussis?	NO	YES
Do you have any severe, life threatening allergies?	NO	YES
Have you fallen into a coma, had decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap) or an influenza vaccine?	NO	YES
Do you have seizures or any other nervous system problem?	NO	YES
Have you ever had Guillain-Barré Syndrome (also called GBS)?	NO	YES
Have you had severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria?	NO	YES

C. CONSENT & AGREEMENT

I have received Vaccine Inventory Statements (VIS) for the vaccines I received today. I understand that Advisory Committee on Immunization Practices (ACIP) recommends waiting in the office for 15 minutes after vaccination administration; I also understand that by leaving the office before the recommended 15-minute waiting period, I do so at my own risk. **BY SIGNING BELOW, I CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS CORRECT AND I ACKNOWLEDGE THAT THIS INFORMATION WILL BE ADDED TO THE CHART OF THE HUDSON HEIGHTS PEDIATRICS PATIENT I AM HERE WITH AND THAT PAYMENT IS DUE TODAY TO HUDSON HEIGHTS PEDIATRICS FOR THE VACCINE I AM RECEVING.**

Patient Signature ______________________ Today's Date ______________________

Patient Printed Name ______________________

To be completed by staff:

Vaccine Administered: ______________________

Lot # ______________________

Expiration Date ____/____/____

Cost: (Due on date of administration)

Flu:	$30	Code: ParentFlu
TDAP:	$65	Code: TDAP