Growing Up Pediatrics, PA
Saturday Flu Clinic
2020-2021

Parent/Guardian Please Complete:

Patient's Name: _____ Date of Birth: _____

Is your child allergic to eggs?	Yes	No
Has your Child had a fever > 101° (F) in the past 24hrs?	Yes	No
Do you have any current COVID19 concerns?	Yes	No
Has your child had a reaction to a previous flu vaccines?	Yes	No

I understand that I am responsible for any flu vaccine or vaccine administration fee at time of service.

X _____ _____

Parent or Guardian Signature Date

For Clinical Staff Only:

Patient Temperature: _____

Brand(circle one): Fluzone Fluarix

Dosage: 0.50 ml

Batch: Lot # _____ Exp Date_____

Provider (circle one): W. Talley, MD C. Wescott, MD C.Gregory, MD V. Byrd, FNP-C

Administered By: _____

Administration Date: _____