PediatriCare Associates
Pediatric and Adolescent Medicine

ADULT VACCINE RELEASE FORM

Date: _____

Child's Name: _____
(Please Print)

Please circle your response:

1.	Are you allergic to eggs?	Yes	No
2.	Are you currently taking an antibiotic for infection?	Yes	No
3.	Do you feel ill today, or do you have a fever?	Yes	No
4.	Do you have a history of Guillain-Barre syndrome?	Yes	No
5.	If you are a female, are you pregnant?	Yes	No

I have read or have had explained to me the information on the "Influenza Vaccine: What you need to know 2014-2015" fact sheet. I have answered the Screen Questionnaire for Injectable Influenza Vaccination truthfully and to the best of my ability. I hereby release and hold harmless PediatriCare Associates, its physicians, staff, and employees from any liability, damage, or claim arising from any injury or complications that may result from my participation in this vaccination program. I understand the benefits and risks of the Flu or Tdap vaccine, and ask that the vaccine be given to me. I will not bill my insurance for this vaccine.

Flu _____

Tdap _____

Name: _____ Date of Birth: ____/____/____
(Please Print)

Signature: _____ Date: _____

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