CONSENT FOR INFLUENZA VACCINATION AND RELATED TREATMENT FOR MINOR WITHOUT A PARENT/LEGAL REPRESENTATION

Consent is required for vaccination of patients under the age of 18 without a parent/legal representative present.

Minor Patient Name:	**Minor Patient Date of Birth:**
Minor Patient Address:	
Emergency Contact: Name: _____ Relationship to Minor: _____ Phone Number: _____	

I am the: ☐ Parent of the minor patient ☐ Legal guardian of the minor patient

☐ Other person with authority to make healthcare decisions on behalf of the minor patient, describe legal relationship: _____

I hereby attest to the following:

- The patient is a minor and eligible for an Influenza Vaccine
- I have the legal authority to consent to the administration of the an Influenza Vaccine to the minor patient
- I have been provided access to the Influenza VIS at the following website: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html
- I understand that I have the option to accept or refuse an Influenza Vaccine on behalf of the minor patient.
- I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine, including but not limited to itching, swelling, fainting, anaphylaxis, and other reactions.
- The minor patient and I agree that the minor patient will remain in the observation area for the required time period following vaccine dose administration.
- I consent to the administration the Influenza Vaccine for the minor patient stated above.

_____

Printed Name of Parent, Legal Guardian, or Other Authorized Individual Date

_____

Signature of Parent, Legal Guardian, or Other Authorized Individual Date