Sutter Health

CONSENT FOR TREATMENT OF A MINOR PATIENT
INFLUENZA VACCINATION

_____ _____ _____

Minor Patient's Name: Date of Birth: Age:

To facilitate medical care and treatment of my child,_____, "Minor Patient," by Sutter Valley or Sutter Bay Medical Foundation the undersigned parent, legal guardian or other person with legal responsibility of the Minor Patient hereby agrees as follows:

1. I reviewed this consent form and understand the potential risks and benefits of the influenza (flu) vaccine.
2. I have the legal authority to consent to have the Minor Patient named above vaccinated with the flu vaccine and am authorized to make health care decisions on behalf of the Minor Patient.
3. I authorize healthcare providers at Sutter Valley or Sutter Bay Medical Foundation to engage in the following acts:

Direct Authorization for administration of vaccine to prevent flu:

[Please Check Box]

☐Flu vaccine

4. I authorize Sutter Valley or Sutter Bay Medical Foundation to provide the Minor Patient with medical care and treatment in my absence.
5. This authorization is given pursuant to the provisions of California Family Code Section 6910.
6. **Duration**: This authorization shall remain effective for 90 days or until_____, 20___. This authorization may be revoked by me at any time prior to that expiration date by providing Sutter Health with written notice.
7. **Exception**: I understand that the provider can decline the consent any time he or she feels it is necessary for the parent/guardian to be present for treatment.

Date:_____ Signature: _____

Print Name: _____

For office use only	MRN #