Parental Consent for Minors
for Administration of Influenza (Flu) Vaccine

I/We, _____,

the [ ] parent(s)
[ ] legal custodian(s);
[ ] legal guardian(s) of the following minor(s):

_____ _____
Student's Name DOB

Hereby give authorization for administration of the following vaccine:

- Influenza (Flu) Vaccine

by health care providers affiliated with the University of South Florida (USF) Student Health and Wellness Center and/or the USF TGH Physicians Group.

Consent is only valid if signed and dated by both the Parent/Legal Custodian/Legal: _____
Print Name

_____ _____
Witness Date

it consent this completed form to one of the below options:

Mail to: University of South Florida
Student Health & Wellness Center
12530 USF Bull Run Drive SWC310
Tampa, FL 33620
Fax to: 813-974-5888