

**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 is 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**