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FLU SHOT

SEASONAL FLU SHOT PATIENT QUESTIONNAIRE 2019- 2020 FLU SEASON

Patient Name: _____ DOB: _____

1. Is your child at least 6 months old? Yes No
2. Has your child ever received the Flu vaccine? Yes No
   a. If your child is under 9 years old, have they received 2 or more doses of the Flu vaccine? Yes No
3. Does your child have any contraindications to receiving the Flu Vaccine (eg: Allergy to eggs, sensitivity to any components of the vaccine-neomycin, history of Guillain-Barre Syndrome)? Yes No
4. Any previous reaction/problem with Flu vaccines: Yes No
5. Has your child had a fever within the past 48 hours Yes No
6. Has your child received a previous Flu vaccine THIS flu season? Yes No
7. If Yes, has 4 weeks elapsed since first dose of Flu vaccine? Yes No

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By signing I acknowledge the following:
I have answered the questions listed above. I have read or have had explained to me the information in the "Vaccine Information Statement" regarding the risk and benefits associated with the influenza vaccination. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine recommended.

Parent/Guardian Signature:		Date Signed	
Physician:		Date Signed	
Administrator of Vaccine:		Date Signed	
Witness of vaccine administration		Date Signed	

For Staff Use Only: Patient Temperature: _____ ☐Oral ☐Axillary

Revised 08/21/2019 HSE