

## FLU QUESTIONNAIRE

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Allergies  
(Food or Medication)

\_\_\_\_\_  
Date

Vaccine screening questionnaire for all patients must be completed and signed with date before any vaccine can be administered. If the vaccine is not covered by either the insurance company or Vaccine For Children (VFC) program, you will be held accountable for any and all charges incurred. These are fee for service procedures.

|                                                                                                                                                                                                                    | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| <p>1. Is the child sick today?</p> <p>Vaccines will be postponed until acute phase of febrile and/or respiratory illness has passed at least 72 hours.</p>                                                         |     |    |
| <p>2. Does the child have any allergies to any medications, food or vaccines, especially egg or egg products, gelatin or neomycin?</p>                                                                             |     |    |
| <p>3. Has the child had a serious reaction to a vaccine in the past?</p>                                                                                                                                           |     |    |
| <p>4. Does the child have cancer, leukemia, AIDS, or any other immune system problem or chronic metabolic disease (including diabetes).<br/><br/>renal function or hemoglobinopathies, congenital or acquired?</p> |     |    |
| <p>5. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs or had x-ray treatments in the past 3 months? Is the patient on aspirin therapy or aspirin containing therapy?</p>            |     |    |
| <p>6. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?</p>                                                               |     |    |
| <p>7. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?</p>                                                                                                         |     |    |
| <p>8. Has the child received any MMR or Chicken Pox vaccine or nasal flu vaccine (seasonal or H1N1) in the past 4 weeks? If so, what:</p>                                                                          |     |    |
| <p>9. Does the patient have any underlying medical condition/chronic disorder of the cardiovascular or pulmonary system. If so, what:</p>                                                                          |     |    |
| <p>10. Does the patient have a history of asthma and/or reactive airway disease?</p>                                                                                                                               |     |    |

|                                                                                                                                                                                                     |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 11. Does the patient have household or close contact with immunocompromised individuals? (*Must stay away from that individual for at least 21 days from Intra-Nasal Flu or it is contraindicated.) |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|

**Form completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Form reviewed by:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Vaccine Information Statement (VIS) given:** \_\_\_\_\_