FLU QUESTIONS 2022-2023

OFFICE USE ONLY:

VFC / Regular

DATE: _____/_____/_____

PATIENT'S NAME: _____ Date of Birth: ____/____ /_____ AGE: _____

(Each patient needs a separate sheet)

Has this patient had any:

1.	Previous flu vaccine?	1. No	Yes
2.	Illness or fever in the last 24 hours?	2. No	Yes
3.	Allergy to EGG or NEOMYCIN?	3. No	Yes
4.	Severe reaction to previous flu vaccine? (e.g. Prolonged fever)	4. No	Yes
5.	Other vaccines (shots) in the last 4 weeks?	5. No	Yes
6.	Oral steroids (Prednisone, Cortisone), radiation treatment, or anti-cancer medication in the past 3 months?	6. No	Yes
7.	Transfusion of blood, blood products or immune globulin in the past year?	7. No	Yes

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WHICH IMMUNIZATION IS THIS PATIENT GETTING TODAY? (PLEASE CIRCLE ONE)

Under 2 years old	Over 2 years old **SHOT**	Over 2 years old **MIST**
(only shot available)	(shot in arm)	(squirt up nose)
		(Not available with all insurance plans)

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Most insurance companies do pay for flu vaccine for children, but Valley Pediatrics cannot guarantee that.

I am aware **my insurance may not pay for this Flu vaccine.** If my insurance company does not pay for this vaccine, I realize I am responsible for the cost, which is $50.00 + administration fee.

PARENT'S SIGNATURE: **X**_____ **Date:** _____/_____/_____

MA Initial: _____