DATE: _____/_____/_____

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

AGE: _____

Does this patient have any history of:

1. Has your child had a fever in the last 24 hours or been ill? No / Yes
2. Is your child allergic to EGG or NEOMYCIN? No / Yes
3. Has the patient had a serious reaction of any prior vaccine? No / Yes
4. Has your child ever had Guillain-Barre syndrome? No / Yes
5. Has your child ever received any previous flu vaccine? No / Yes

Which immunization are you getting today (PLEASE CIRCLE):

Under 3 years old Over 3 years old

As explained to me by the staff of Valley Pediatric Associates, occasionally some insurance plans 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:

Under 3 $50.00 + administration fee
Over 3 $35.00 + administration fee

PARENT'S SIGNATURE: **X**_____

VFC Non-VFC