

DATE: ____/____/____

PATIENT'S NAME: _____

Date of Birth: ____/____/____

AGE: _____

Does this patient have any history of the following...

- 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?
(ANY flu shot ever in their entire lives in ANY previous year) 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:

\$50.00 + administration fee

PARENT'S SIGNATURE: X _____

For STAFF ONLY:

VFC

Non-VFC

TEMP: _____