OFFICE USE ONLY:
VFC / Regular

TEMP=______

FLU QUESTIONS 2020-2021

DATE: ______/_____/_____

PATIENT'S NAME: ___________________________ Date of Birth: ____/____ /_____ AGE: ________
(Each patient needs a separate sheet)

Does this patient have any:

1. Illness or fever in the last 24 hours? 1. No / Yes
2. Allergy to EGG or NEOMYCIN? 2. No / Yes
3. Previous flu vaccine? 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 or blood products or immune globulin in the past year? 7. No / Yes
8. Asthma, Wheezing, or used a nebulizer or inhaler in the past 12 months? 9. No / Yes

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

Under 3 years old (only shot if under 3)	Over 3 years old SHOT (needle in arm)	Over 3 years old MIST (squirt up nose)

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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:** ______/_____/_____