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? 1. No / Yes
2. Is your child allergic to EGG or NEOMYCIN? 2. No / Yes
3. Has the patient had a serious reaction of any prior vaccine? 3. No / Yes
4. Has your child received oral steroids (Prednisone, Cortisone), had radiation treatment, or been on anti-cancer medication in the past 3 months? 4. No / Yes
5. Has your child received a transfusion of blood or blood products or immune globulin in the past year? 5. No / Yes
6. Has your child received any vaccines (shots) in the last 4 weeks? 6. No / Yes
7. Has your child received any previous flu vaccine? 7. No / Yes
8. Does your child have Asthma, Wheezing, or used a nebulizer or inhaler in the past 12 months? 8. No / Yes

Which immunization are you getting today (PLEASE CIRCLE):
(ALL of our flu shots this year contain 4 components (Quadravalent). In previous years there were only 3 (Trivalent). This means it protects against more strains of flu).

Under 3 years old	Over 3 years old SHOT (needle in arm)	Over 3 years old MIST (squirt up nose)

As explained to me by the staff of Valley Pediatric Associates, 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:

Flumist	$40.00 + administration fee
Under 3	$40.00 + administration fee
Over 3	$25.00 + administration fee

PARENT'S SIGNATURE: X_____