FLU QUESTIONS 2024-2025

DATE: ______/______/______

OFFICE USE ONLY:

VFC / Regular

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

Has this patient had any:

1.	Previous flu vaccine? (2 doses for 1st time getting flu vaccine + under 9)	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, anti-cancer medication or anit-viral (Tamiflu, Relenza, Peramavir, Baloxavir) in the past 3 months? (Shot only, cannot get MIST)	6.	No	Yes
7.	Transfusion of blood, blood products or immune globulin in the past year? (Shot only, cannot get mist)	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)

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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: ______