Patient Name________________________________

Patient DOB_____________________Age__________

2022-2023

Pediatric Influenza Questionnaire/Consent Form

Y N Does your child have any health problems/chronic illness?

Please list ___________________________________

Y N Has your child been diagnosed with asthma or wheezing within the last 12 months?

Y N Has your child been ill with a fever, decreased appetite, cold symptoms, etc in the past 3 days?

Y N Has your child ever received the flu shot or nasal mist? Is yes, when?______________

Y N Has your child experienced any severe reaction to previous flu shot or nasal mist?

If yes, what?________________________

Y N Any risk of pregnancy?

Y N Does your child have any allergy to Egg, MSG, Gentamicin, or Gelatin? (Please circle)

Y N Is your child allergic to any medications or food? Please List____________________

Y N Does your child have a history of any Seizure disorders?

Y N Does he/she have any close contact of patients with immunosuppression (ex: chemo therapy)? Please explain_________________________

Y N Has your child had Guillain-Barre Syndrome?

Y N Has your child been taking oral steroid medication in the last 14 days?

Y N Has your child had any vaccines in the last 4 weeks? If yes, what? ________

Y N Is your child receiving aspirin therapy?

Y N Has your child received influenza antiviral medications in the last 48 hours (e.g. Tamiflu)

Parent or Guardian Signature:__________________________________ Date________________

Office Use:

(Sticker if available)

Vaccine type	Lot #	Site	Route	Staff	Date	Epic
		R / L D / T	IM IN			