Influenza Vaccine Pediatric Screening Record

Patient's Name: ______________________________

(please print)

Date of Birth: ______________________________

The following questions will help us decide if there is any reason we should not give your child a Flu vaccine. If you answer **Yes to any of the questions below, please inform the provider** before the vaccine is given. If a question is not clear, please ask us to explain it.

Please circle answers to the questions below:			
1. **Does your child have a problem eating eggs?**	Yes	No	Not Sure
2. Is your child sick or feverish today?	Yes	No	Not Sure
3. Has your child ever had Guillain-Barré syndrome (a paralyzing illness)?	Yes	No	Not Sure
4. Has your child ever had a serious reaction to the Flu vaccine?	Yes	No	Not Sure
5. Is your child allergic to Gentamycin, Neosporin, Polymixin or gelatin?	Yes	No	Not Sure

If you have doubts about giving the vaccine, a Flu clinic is not the right time or place to discuss them. Call your pediatrician at another time to discuss and reschedule.

In order for your child to be vaccinated, you must check the box below.

☐ I have read the Flu Vaccine Information Sheet and give permission for my child to be vaccinated.

______________________________ ______________
Signature of parent or guardian **Date**

For Clinical / Office Use

☐ Illness Assessment ☐ Questionnaire Reviewed

Site: ______________ Lot # ______________

Name/Title of vaccine administrator **(Print Name please):**

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