PROVIDENCE PEDIATRIC PRACTICE
INFLUENZA VACCINATION SREENING QUESTIONNAIRE

Patient's Name: _____Date of Birth :_____
Address: _____
City: _____State:_____ Zip Code_____
Home Phone: _____Emergency Contact Name and Phone:_____
Insurance Carrier: _____

1. Has your child had a fever of 100.4 or greater within the past 48 hours? YES NO
2. Has your child ever had a serious reaction to the Flu Vaccine? YES NO
3. Does your child have an immunocompromising condition (ie cancer, leukemia, lymphoma, kidney removed, CSF leak, cochlear transplant, etc) or take any medication (ie steroids or chemotherapy) that lower the body's resistance to infection? YES NO
4. Does your child have asthma or recurrent or active wheezing? YES NO
5. Does your child have close contact with anyone who has a weakened immune system (ie receiving chemotherapy or has had a bone marrow transplant). YES NO
6. Does your child have any known allergies? Yes (specify_____)YES NO
8. Has your child received a vaccine within the past 30 days? YES NO
   If yes, please specify_____

Please complete this form before your visit, preferably the day the vaccine is to be administered to ensure accurate reporting of symptoms. Please alert our office if you have answered YES to any of the above questions. Be prepared to wait for 10 minutes after the flu vaccine has been administered to make sure that your child does not have an adverse reaction – this is mandated by your Doctor, the American Academy of Pediatrics and the CDC.

Patient/parent/guardian Signature: _____
Printed Name and relationship of above: _____
Today's Date:_____

Please circle Vaccine Preference:

Injection

Mist (over 2 yrs old AND no albuterol use for acute asthma or wheezing in past 6 months)

English
Influenza (Flu) Vaccine
(Inactivated or Recombinant)

Influenza (Flu) Vaccine
(Live, Intranasal)