

**THE PEDIATRIC CENTER, LLC**  
**FLU VACCINE QUESTIONNAIRE AND WAIVER 2 2019-2020**

1/1    1/2    2/2

Appointment Date: _____		Account # _____	
Patient Name: _____		Date of Birth: ____ / ____ / ____	Age: _____
Patient Address: _____			
<small>Street</small>		<small>City</small>	
<small>State</small>		<small>Zip</small>	
Home Phone # _____		Cell Phone # _____	
Paid: Cash \$ _____	Check \$ _____ # _____	Charge \$ _____	Visa    MC    Discover

Please answer the following questions:

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is the child under 3 years of age?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you/your child sick today? Vaccine will be postponed until acute phase of febrile and/or respiratory illness has passed at least 24 hours.   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the child have allergies to any medication, foods or vaccines especially egg or egg products, gelatin or Neomycin?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has the child had a serious reaction to a vaccine in the past?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has the child had a seizure, inflammation of the brain (encephalopathy) or history of Guillain-Barre Syndrome?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the child have cancer, leukemia, AIDS or any other immune system problem or chronic metabolic disease including diabetes, decreased renal function, hemoglobinopathy, congenital or acquired? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has the child taken cortisone, prednisone other steroids or anti cancer drugs or had x-ray treatments in the past 3 months? Is the patient on aspirin therapy or aspirin containing therapy?       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has the child received a transfusion of blood or blood products or been treated with immune gamma globulin in the past year?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is the child /teen pregnant or there is a chance that she could become pregnant in the next month?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has the child received any vaccinations or medication in the past four weeks? If yes, what immunization or medications?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the patient have any underlying medical condition or chronic disorder of the cardiovascular and or pulmonary system?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does the patient have a history of asthma or reactive airway disease?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | To the best of your knowledge, did you / your child receive any flu vaccine during the 2017/18 or 2018/19 influenza season? If yes, how many doses? _____  |

\* If Yes to Allergies, please list : \_\_\_\_\_

**INSURANCE WAIVER**

I understand that my insurance company may not cover the cost of the Influenza vaccine. If they do not, I agree to pay the full cost of the vaccine(s). **The Pediatric Center, LLC will not be submitting the influenza vaccine to insurance for parents who receive the vaccine at our office.**

⇒ **Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Today's Date: _____		FOR EMPLOYEE USE ONLY	
Administered by: _____		Date of Last Flu Shot: _____	
Dose given (flu shot):	<input type="checkbox"/> 0.5ml <input type="checkbox"/> 0.25ml	Administration Site:	<input type="checkbox"/> left arm <input type="checkbox"/> left quad <input type="checkbox"/> right arm <input type="checkbox"/> right quad <input type="checkbox"/> intra nasal
Dose given (FluMist only)	<input type="checkbox"/> 0.2ml	2 <sup>nd</sup> dose required	<input type="checkbox"/> Yes <input type="checkbox"/> No    CDC VIS dated 8/7/15 given

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_