Flu Clinic 2020-2021

The Pediatric Center will be offering drive thru flu clinics this year in order to protect the health of our patients and our staff. They will be held two weekends per month beginning September 26 and 27th by appointment only. Please call the office at 443-451-1600 to schedule

ALL FLU QUESTIONAIRES MUST BE COMPLETED PRIOR TO ARRIVAL. Remember EACH CHILD receiving a flu vaccine requires a questionnaire. (Link to Questionnaire)

IF YOUR QUESTIONAIRE IS NOT COMPLETE, YOU WILL BE ASKED TO PULL INTO A PARKING SPOT TO COMPLETE IT AND THEN GET BACK IN LINE

If you child is under 12 months of age please have the child's leg exposed.
If your child is over 12 months of age please have the upper arm exposed.

There will be additional times available in the office. Please call for more information.

THE PEDIATRIC CENTER, LLC

FLU VACCINE QUESTIONNAIRE AND WAIVER 2020-2021

1/1 1/2 2/2

Appointment Date: Account #

Patient Name: ______________________ Date of Birth: ___/___/____ Age: ________

Patient Address: ____
Street City State Zip

Home Phone # ______________________ Cell Phone # ______________________

Paid: Cash $ ________ Check $ ________ # ______ Charge $ ________ Visa MC Discover

Please answer the following questions:

☐ Yes	☐ No	Is the child under 3 years of age?
☐ Yes	☐ 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.
☐ Yes	☐ No	Does the child have allergies to any medication, foods or vaccines especially egg or egg products, gelatin or Neomycin?
☐ Yes	☐ No	Has the child had a serious reaction to a vaccine in the past?
☐ Yes	☐ No	Has the child had a seizure, inflammation of the brain (encephalopathy) or history of Guillain-Barre Syndrome?
☐ Yes	☐ 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?
☐ Yes	☐ 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?
☐ Yes	☐ No	Has the child received a transfusion of blood or blood products or been treated with immune gamma globulin in the past year?
☐ Yes	☐ No	Is the child /teen pregnant or there is a chance that she could become pregnant in the next month?
☐ Yes	☐ No	Has the child received any vaccinations or medication in the past four weeks? If yes, what immunization or medications?
☐ Yes	☐ No	Does the patient have any underlying medical condition or chromic disorder of the cardiovascular and or pulmonary system?
☐ Yes	☐ No	Does the patient have a history of asthma or reactive airway disease?
☐ Yes	☐ No	To the best of your knowledge, did you / your child receive any flu vaccine during the 2018/19 or 2019/20 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): ☐ 0.5ml ☐ 0.25ml Administration Site: ☐ left arm ☐left quad ☐right arm ☐right quad ☐intra nasal

Dose given (FluMist only) ☐ 0.2ml 2nd dose required ☐Yes ☐No CDC VIS dated 8/7/15 given

Reviewed by: ______________________________ Date: ____________