THE PEDIATRIC CENTER, LLC

FLU VACCINE QUESTIONNAIRE AND WAIVER 2018-2019

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 2016/17 or 2017/18 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:** _____

FOR EMPLOYEE USE ONLY

Today's Date: _____

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: _____