Influenza Vaccine Screening Questionnaire - CHILD

Patient Name:_____

Patient DOB:_____

Date:_____

Flu Vaccine for 2020-2021
The quadrivalent influenza vaccine for 2020-2021 includes an A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like virus, A/Hong Kong/2671/2019 (H3N2)-like virus, B/Washington/02/2019 (B/Victoria lineage)-like virus, B/Phuket/3073/2013-like (Yamagata lineage) virus

For vaccine recipients: Please answer the following questions. If the questions are unclear, please ask your healthcare provider. A parent must complete the form for children < 18 years of age.

1. Has your child had a fever in the last 24 hours? _____ Yes _____ No _____Unsure

2. Does your child have any allergies to medications, food chemicals, latex or any vaccine? If yes, please describe: _____. _____ Yes _____ No _____Unsure

3. Has your child had a serious reaction to the flu vaccine in the past? If yes, please describe: _____. _____ Yes _____ No _____Unsure

4. Has your child had a neurological illness, such as Guillain-Barre' syndrome (a progressive paralysis of the body)? _____ Yes _____ No _____Unsure

Flu Mist Only Questions

5. Has a healthcare provider told you that your child has had wheezing or asthma in the last 12 months? _____ Yes _____ No _____Unsure

6. Do you plan on having close contact within the next 7 days with any individuals who immune system is severely compromised? _____ Yes _____ No _____Unsure

7. Has your child received the MMR or Chickenpox vaccine in the last four (4) weeks? _____ Yes _____ No _____Unsure

I was counseled on the vaccine including potential side effects and was given the opportunity to ask questions which were answered to my satisfaction.

Parent Signature: _____ Date: _____