PEDIATRIC - SCREENING QUESTIONNARIE AND AUTHORIZATION FOR INFLUENZA VACCINE

PATIENT NAME: _____ **DOB:** _____

For parents/guardians: The following questions will help us determine whether your child can receive the influenza vaccine today. If you answer "Yes" to any questions it does not necessarily mean that your child cannot receive the vaccine. It just means that we may need to ask additional questions.

	Yes	No	Don't Know
1 Which influenza vaccine are you requesting? **Flu Shot** ☐ **FluMist (nasal vaccine)** ☐			
2. Is the child sick today?	☐	☐	☐
3. Has the child had a fever within the last 48 hours?	☐	☐	☐
4. Has the child had a reaction to the Influenza vaccine or any other vaccine in the past? If "Yes" which one?	☐	☐	☐
5. Is the child allergic to eggs, egg products, gelatin, gentamicin or arginine?	☐	☐	☐
6. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
7. Does the child have a prior history of Gullian-Barre Syndrome (GBS)?	☐	☐	☐
8. Does your child have a chronic condition or health problem? **If yes, check all that apply.** ☐Asthma ☐Diabetes ☐Heart Disease ☐Kidney Disease ☐Liver Disease ☐Lung Disease ☐Other _____	☐	☐	☐
9. **For FluMist only -** Does your child have a history of asthma or wheezing?	☐	☐	☐
10. **For FluMist only -** Does your child have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or is he/she in contact with anyone who has a severely weakened immune system?	☐	☐	☐
11. **For FluMist only -** Has your child received the MMR or Varicella vaccine in the past 4 weeks?	☐	☐	☐
12. **For FluMist only** - Is your child taking aspirin, Tamiflu, amatadine or rimantadine?	☐	☐	☐
Form completed by (Parent or Legal Guardian):	Date:		
Form reviewed by:	Date:		

If you choose to have your child immunized with the Influenza Virus Vaccine, please read the following information and sign below.

1. I agree that the above named child will receive the Influenza Virus Vaccine.
2. The CDC Vaccine Information Statement has been provided to me with all the necessary information so I can make an informed decision.
3. I understand the risks of the Influenza Virus Vaccine.
4. I understand that the Influenza Virus Vaccine is highly recommended for anyone with the following health conditions: heart disease, lung disease, asthma, kidney disease, metabolic diseases (such as diabetes) and persons over the age of 6 months.
5. I have been provided the opportunity to ask questions about the disease, the vaccine, and how the vaccine is to be administered.
6. I know that the above named child will have the vaccine injected into his/her body to help prevent the Influenza virus.
7. I am a competent adult who can legally consent for the above named child to receive this vaccine. I am freely and voluntarily providing my signed permission for this vaccine to be administered.
8. **Payment:** Because the Influenza Virus Vaccine is not yet part of the requried immunization schedule. Because the reimbursement policies of many insurers may not have been established, parents who choose to have their child immunized with the influenza virus vaccine must understand they may be billed for any portion of these charges that their insurance will not pay.

By signing below you authorize Austin Children's Clinic, PA to administer the Influenza Virus Vaccine to the above named child. You also agree to pay any unpaid charges for this vaccine.

Authorizing Signature: _____ Date: _____

Relationship to patient: _____