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FLU VACCINE SCREENING QUESTIONNAIRE

Patient Name:______________________________________ Date of Birth:________________

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give your child a flu vaccine today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO
1. Is your child sick today?		
2. Does your child have an allergy to eggs, neomycin, or latex?		
3. Has your child ever had a serious reaction to a vaccine in the past?		
4. Does your child have a history of asthma or wheezing, kidney disease, heart problems, diabetes, or other chronic illness?		
5. Has your child been on aspirin therapy, oral steroids, immune (gamma) globulin, or other medications that might suppress their immune system in the past 3 months?		
6. Has your child received a vaccination of any type in the past 4 weeks?		
7. Has your child ever had a flu vaccine?		

Guardian signature:______________________________________ Date:____________