Pediatrics of Akron Flu Vaccine Screening Form

Please complete this form so we may better assess your child's eligibility for the appropriate Flu Vaccine.

Child's Name ______________________________ Date of Birth _______________ Age ______

Children over the age of 2 ***may*** qualify for Flu Mist.
Children over 6 months and under 2 years will receive injectable flu vaccine.

YES	NO	**Do any of the following apply to your child?**
☐	☐	Allergy to eggs, latex,
☐	☐	Life threatening reactions to influenza vaccine or other vaccines in the past
☐	☐	Receiving aspirin therapy or aspirin-containing therapy
☐	☐	Has experienced wheezing in the last 6 months
☐	☐	Has used an albuterol inhaler in the last year
☐	☐	Diagnosed with asthma
☐	☐	Wheezing under the age of 5
☐	☐	Experienced Guillain-Barre syndrome
☐	☐	Long term health problems with weakened immune system,(heart, liver, kidney, or metabolic disease(diabetes), anemia or other blood disorders
☐	☐	Been vaccinated with any vaccine (not just flu) within the past 30 days?
☐	☐	Expect to have close contact within the next 7 days with anyone whose immune system is severely weakened? (such as bone marrow/organ transplant)

CONSENT

I have accurately answered the above questions as well as reviewed the vaccine information sheet on flu vaccine. I have had the opportunity to ask questions and fully understand the benefits and risks of influenza vaccination. ***My signature in the box below indicates consent for my child to receive influenza vaccine.***

Vaccine & route	Date given	Site LA, RA, LT, RT, IN	Vaccine lot number	Vaccine manufacturer	VIS date*	Signature or initials of vaccine administrator	***SIGNATURE OF PARENT OR GUARDIAN***
Fluzone 0.25 ml 0.5 ml FluMist				 Sanofi Sanofi Medimmune			

***** ***If your child is ill with fever or acute illness we will be unable to vaccinate today, please call tomorrow for an appointment.***