ABCD Pediatrics

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Flu Vaccine Questionnaire

Please complete all questions about your child prior to receiving the Flu Vaccine. Complete one for each child.

Child's Name: _____ Date of Birth: _____ Today's Date: _____

Has your child ever been given the Flu Vaccine in the past?	Yes	No
Has your child ever had a reaction to a Flu Vaccine?	Yes	No
Does your child have asthma, wheezing or breathing problems?	Yes	No
Is your child allergic to eggs or egg protein?	Yes	No
Has your child ever had a reaction to eggs involving swelling of the face and respiratory distress?	Yes	No
Is your child allergic to gentamicin?	Yes	No
Is your child allergic to gelatin?	Yes	No
Is your child allergic to arginine?	Yes	No
Has your child ever had Guillain-Barre' Syndrome?	Yes	No
Is your child on aspirin therapy? (Between 2-17 years old only)	Yes	No
Has your child been sick or had fever within the last 48 hours?	Yes	No
Has your child received any vaccines within the last 4 weeks?	Yes	No

I give permission for my child, named above to receive the flu vaccine

Signature: _____ Printed Name (Parent/ Guardian): _____

Administered by: _____

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