Pediatric Influenza Vaccine Screening Questionnaire

For parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give your child the influenza vaccination 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.

PATIENT NAME (Please Print): Age: DOB:

**Mark answers by checking “YES” or “NO” for questions 1-5 YES NO**

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| --- | --- | --- |
| 1. If your child is between 6 months and 8 years of age, has your child received at least 2 doses of flu vaccine in the previous flu season (s)? |  |  |
| 2. Does your child feel sick or have a fever today? |  |  |
| 3. Has your child had an allergic reaction after a previous dose of the influenza vaccine, or has any severe, life-threatening allergies? |  |  |
| 4. Does your child have a history of developing Guillain-Barre Syndrome (muscle paralysis within 6 weeks of receipt of an influenza vaccine)? |  |  |

- I have read the above information and have truthfully answered all the questions on this form.

- I have received a copy of the Vaccine Information Statement (VIS) for each vaccine administered.

- I have had the chance to ask questions and fully understand the benefits and risks of each vaccination

- Questions answered above as “Yes” may need further explanation.

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Signature of Parent/Guardian of child/Self if 18 yrs or older Date