Ellicott City Pediatric Associates PA

Office use
TEMP: _____ COVID SCREEN: _____

Patient Name:_____ Visit Date:_____

Date of Birth:_____ Age:_____

Flu Vaccine Questionnaire

1. Is this the **first** flu vaccine this patient has **ever** received? *Yes* *No*
2. Has the patient received any flu vaccine **this flu season (August-May)**? *Yes* *No*
3. Is the patient allergic to eggs, Neomycin, gelatin, thimerosal or Arginine? *Yes* *No*
4. Has the patient ever had a serious reaction to the flu vaccine? *Yes* *No*
5. Does the patient have an immune deficiency such as: cancer, HIV/AIDS, on chemotherapy or radiation, on long-term steroids, on immune suppressing medications, or on aspirin therapy, and been advised not to have any vaccinations? *Yes* *No*
6. Is the patient pregnant OR breastfeeding? *Yes* *No*
7. Have you ever been told your child has Guillian-Barre'? *Yes* *No*
8. Is the patient **sick** today? *Yes* *No*

By signing this form, I give permission to be vaccinated and agree that the above information is correct. I have been offered the *Vaccine Information Sheet (08/15/2019)* and had my questions answered.

***NOTE: FLU MIST IS UNAVAILABLE AT ECPA FOR THIS FLU SEASON.**

Signature: _____ (**patient or guardian**) Date:_____

**** FOR OFFICE USE ****

Stock :_____**VFC / REG**_____(circle one) Lot #: _____

Dose administered: _____ Expiration Date: _____

Where Administered: _____ **IM**

*Reviewed & Administered by:*_____*Date:*_____

*NOTES:*_____