INFLUENZA VACCINE PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

Primary Care Physician: _____

1. Vaccine Information Statement given:	Yes	No
2. Allergy to eggs/poultry:	Yes	No
3. Allergy to the preservative Thimerosal:	Yes	No
4. Allergy to latex:	Yes	No
5. Received flu vaccine in past:	Yes	No
If yes, approximate date of last dose: _____		
7. Any previous reaction/problem with flu vaccines:	Yes	No
8. Ever paralyzed by Guillian-Barre Syndrome:	Yes	No
9. Currently experiencing any moderate or severe illness:	Yes	No
10. Is your child less than 3 years of age:	Yes	No

By signing I acknowledge the following:
I have read or have had explained to me the information in the "Vaccine Information Statement" regarding the risk and benefits associated with the influenza vaccination. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine recommended.

_____ Date: _____
Parent/Guardian Signature

For Office Use Only

Vaccine: Fluzone **Manufacturer:** Aventis **Lot #:** _____

Dose: 0.25ml or 0.5ml IM **Site:** Left or Right
Thigh or Deltoid

_____ Date: _____
Administering Clinician's Signature

Pediatric Questionnaire