PEDIATRIC INFLUENZA VACCINE PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

Primary Care Provider: _____

1. Vaccine Information Statement given: Yes No
2. Allergy to any of the following:
   - Eggs/Poultry Yes No
   - Pork Yes No
   - Latex Yes No
   - Preservative thimersol Yes No
   - Neomycin or neosporin Yes No
3. Any previous reaction /problem with flu vaccines: Yes No
4. Ever paralyzed by Guillian-Barre Syndrome: Yes No
5. Currently experiencing any moderate to severe illness: Yes No
6. Is your child less than 3 years of age: Yes No

For Office Use Only

Vaccine: _____ **Manufacturer:** _____ **Lot#:** _____

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

_____ Date: _____

Administering Clinician's Signature