Caring Hands Children's Clinic, LLC
Influenza Screening Questionnaire
2013-2014 Influenza Season

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

This form MUST be completed BEFORE your child receives a flu vaccination.
I am requesting that my child be vaccinated with:

_____ **Flu Shot** _____**Flu Mist**

Please answer the following questions:

1. Is your child over **6 months** of age? **Yes / No** (for Flu Shot)

2. Is your child **2 years** old or older? **Yes / No** (for Flu Mist)

3. Does your child have an allergy to latex? **Yes** / **No**

4. In the previous twelve months has a health care professional told you that your child has wheezing? **Yes / No**

5. Does your child have any chronic pulmonary, cardiovascular, metabolic or immune disorder? **Yes / No**

6. Has your child ever had an allergic reaction to a prior flu vaccination? **Yes / No**

7. Has your child ever had an allergic reaction to eggs? **Yes / No**

- If you answered yes to the above question did your child have:
  Hives / difficulty breathing / wheezing / vomiting / dizziness / confusion / throat swelling / low blood pressure? Please circle all that apply

8. Has your child ever been diagnosed with Guillain-Barre syndrome? **Yes / No**

9. Has your child received the flu vaccine in the last two years? **Yes / No**

10. If applicable: Is your adolescent child pregnant? **Yes / No**

I have been provided with a copy of the Vaccine Information Statement. I understand the risks and benefits of this immunization and wish to proceed.

_____ _____
Parent/Guardian signature Date

For the health care provider:
Has the patient had the MMR or Varicella vaccines in the last 4 weeks? ***Yes / No***

*Date last live vaccine administered:*_____