

2017 – 2018 Center City Pediatrics Flu Questionnaire - Philadelphia

Private / VFC

Room Number: _____

Patient Number: _____

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

Has your child had a previous flu shot this season? • If yes, was the first dose given 28 days or more ago?	YES / NO YES / NO
Is your child under 9 years old? • Has your child had at least 2 doses of influenza vaccine prior to July 1, 2017?	YES / NO YES / NO
Has your child had a fever of 101F or higher within the past 24 hours? • If yes, not a candidate for Walk-In Flu Clinic without further nurse assessment.	YES / NO
Does your child have a history of Guillain-Barre Syndrome? • If yes, not a candidate for Walk-In Flu Clinic; must discuss with physician.	YES / NO
Does your child have a history of a serious adverse reaction or allergic reaction to prior flu shot? • If yes, not a candidate for Walk-In Flu Clinic; must discuss with physician.	YES / NO

I have received a Vaccine Information Sheet (VIS) from the CDC and have read, or have had explained to me, information about the FLU vaccine. I had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the FLU vaccine and ask that the FLU vaccine be given to the person named above for whom I am authorized to make this request.

Parent/Guardian Signature: _____

Print Parent Guardian Name: _____

Relationship to Child: _____

Back Office Use Only:

MA Initials: _____ Lot #: _____ Site of Injection: _____

Dosage: _____ Exp Date: _____ Mfr: Sanofi

Charges Billed