# 2018 – 2019 Center City Pediatrics Flu Questionnaire - Philadelphia

Today's Date: _____ Private / VFC

Room Number:_____ Patient Number: _____

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

| | |
|---|---|
| Has your child had a flu shot after July 1st of this year?<br>• If yes, was the first dose given 28 days or more ago? | YES / NO<br>YES / NO |
| Is your child under 9 years old?<br>• Has your child ever had 2 doses of influenza vaccine in the same flu vaccine? (August through June) | YES / NO<br>YES / NO |
| Has your child had a fever of 101F or higher within the past 24 hours?<br>• 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?<br>• 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?<br>• 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: _____

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Back Office Use Only:

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

Dosage: _____ Exp Date: _____ Mfr: Sanofi

*Charges Billed*