

**PEDIATRIC - SCREENING QUESTIONNAIRE AND AUTHORIZATION FOR INFLUENZA VACCINE**

**PATIENT NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**For parents/guardians:** The following questions will help us determine whether your child can receive the influenza vaccine today. If you answer "Yes" to any questions it does not necessarily mean that your child cannot receive the vaccine. It just means that we may need to ask additional questions.

	Yes	No	Don't Know
1. Which influenza vaccine are you requesting? <b>Flu Shot</b> <input type="checkbox"/> <b>FluMist (nasal vaccine)</b> <input type="checkbox"/>			
2. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a fever within the last 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a reaction to the Influenza vaccine or any other vaccine in the past? If "Yes" which one?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the child allergic to eggs, egg products, gelatin, gentamicin or arginine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a prior history of Gullian-Barre Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child have a chronic condition or health problem? <b>If yes, check all that apply.</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. <b>For FluMist only</b> - Does your child have a history of asthma or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. <b>For FluMist only</b> - Does your child have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or is he/she in contact with anyone who has a severely weakened immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. <b>For FluMist only</b> - Has your child received the MMR or Varicella vaccine in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. <b>For FluMist only</b> - Is your child taking aspirin, Tamiflu, amatadine or rimantadine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by (Parent or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**If you choose to have your child immunized with the Influenza Virus Vaccine, please read the following information and sign below.**

- I agree that the above named child will receive the Influenza Virus Vaccine.
- The CDC Vaccine Information Statement has been provided to me with all the necessary information so I can make an informed decision.
- I understand the risks of the Influenza Virus Vaccine.
- I understand that the Influenza Virus Vaccine is highly recommended for anyone with the following health conditions: heart disease, lung disease, asthma, kidney disease, metabolic diseases (such as diabetes) and persons over the age of 6 months.
- I have been provided the opportunity to ask questions about the disease, the vaccine, and how the vaccine is to be administered.
- I know that the above named child will have the vaccine injected into his/her body to help prevent the Influenza virus.
- I am a competent adult who can legally consent for the above named child to receive this vaccine. I am freely and voluntarily providing my signed permission for this vaccine to be administered.
- Payment:** Because the Influenza Virus Vaccine is not yet part of the required immunization schedule. Because the reimbursement policies of many insurers may not have been established, parents who choose to have their child immunized with the influenza virus vaccine must understand they may be billed for any portion of these charges that their insurance will not pay.

**By signing below you authorize Austin Children's Clinic, PA to administer the Influenza Virus Vaccine to the above named child. You also agree to pay any unpaid charges for this vaccine.**

Authorizing Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_