PEDIATRIC - SCREENING QUESTIONNARIE AND AUTHORIZATION FOR INFLUENZA VACCINE

Which influenza vaccine are you requesting? Flu Shot FluMist (nasal vaccine) Is the child sick today?	PATIENT NAME:	_ DOB:		
Which influenza vaccine are you requesting? Flu Shot FluMist (nasal vaccine) Is the child sick today?				
Is the child sick today? Has the child had a fever within the last 48 hours? Has the child had a fever within the last 48 hours? Has the child had a reaction to the Influenza vaccine or any other vaccine in the past? If "Yes" which one? Is the child allergic to eggs, egg products, gelatin, gentamicin or arginine? Is the child allergic to eggs, egg products, gelatin, gentamicin or arginine? Is the child have a prior history of Gullian-Barre Syndrome (GBS)? Does the child have a prior history of Gullian-Barre Syndrome (GBS)? Does your child have a chronic condition or health problem? If yes, check all that apply. Asthma		Yes	No	Don't Know
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