

Date: _____

Date of birth: _____

Patient name: _____
Last First

Is your child allergic to eggs? _____

Does your child have asthma? _____

Has your child wheezed or needed a breathing treatment
or inhaler in the last year? _____

Has your child had any adverse reaction to vaccines? _____

Does your child have any immune deficiencies
or other health problems? _____

Has your child had a flu mist, MMR or chicken pox vaccine
in the last 30 days? _____

Is your child currently ill or had a fever in the past 48 hours? _____

Has your child had Guillain – Barre syndrome? _____

Is there a possibility your child could be pregnant? _____

“I have read or have had explained to me information about the indicated vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the indicated vaccine be given to me or the named person for whom I am authorized to make the request.”

Sticker here

Site given:
Intranasal

Signature of vaccine admin:

Signature of parents:

Seasonal Influenza Vaccine 2011/12 - Flumist