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**FLU SHOT**

**SEASONAL FLU SHOT PATIENT QUESTIONNAIRE 2025-2026 FLU SEASON**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child at least 6 months old? Yes No
2. Has your child ever received the Flu vaccine? Yes No
3. If your child is under 9 years old, have they received 2 or more doses

 of the Flu vaccine by July 1, 2025? Yes No

1. Does your child have any contraindications to receiving the Flu Yes No

Vaccine (eg: Allergy to eggs, sensitivity to any components

of the vaccine-neomycin, history of Guillain-Barre Syndrome)?

1. Any previous reaction/problem with Flu vaccines: Yes No
2. Has your child had a fever within the past 48 hours Yes No
3. Has your child received a previous Flu vaccine THIS flu season? Yes No

1. If Yes, has 4 weeks elapsed since first dose of Flu vaccine? Yes No

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**By signing I acknowledge the following:**

I have answered the questions listed above. I have read or have had explained to me the information in the “Vaccine Information Statement” regarding the risk and benefits associated with the influenza vaccination. 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 recommended.

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| --- | --- | --- | --- |
| Parent/Guardian Signature:  |  | Date Signed |  |
| Physician:  |  | Date Signed |  |
| Administrator of Vaccine: |  | Date Signed |  |
| Witness of vaccine administration |  | Date Signed |  |

For Staff Use Only: Patient Temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_ ⎕Skin ⎕Oral ⎕Axillary

Revised 07/10/2025 HSE