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FLU SHOT

SEASONAL FLU SHOT PATIENT QUESTIONNAIRE 2026-2027 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
	a. If your child is under 9 years old, have they received 2 or more doses of the Flu vaccine by July 1, 2026?	Yes	No
3.	Does your child have any contraindications to receiving the Flu Vaccine (eg: Allergy to eggs, sensitivity to any components of the vaccine-neomycin, history of Guillain-Barre Syndrome)?	Yes	No
4.	Any previous reaction/problem with Flu vaccines:	Yes	No
5.	Has your child had a fever within the past 48 hours	Yes	No
6.	Has your child received a previous Flu vaccine **THIS** flu season?	Yes	No
7.	If Yes, has 4 weeks elapsed since first dose of Flu vaccine?	Yes	No

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.

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 08/27/2026 HSE