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FLUMIST

SEASONAL FLUMIST PATIENT QUESTIONNAIRE 2026-2027 FLU SEASON

Patient Name: _____ DOB:_____

1.	Is your child at least 2 years old?	Yes	No
2.	Has your child ever received the Flu vaccine?	Yes	No
	a. If Yes, has your child received 2 or more doses of the Flu vaccine prior to 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.	Has your child had any previous reaction/problem with Flu vaccines?	Yes	No
5.	Has your child had a fever within the past 48 hours?	Yes	No
6.	Does your child have a history of asthma, wheezing, or albuterol use?	Yes	No
7.	Does your child have any other metabolic diseases, including diabetes or renal dysfunction?	Yes	No
8.	Has your child received any other live vaccines (MMR, Varivax or Flumist) within the past 4 weeks?	Yes	No
9.	Does your child have sickle cell disease?	Yes	No
10.	Has your child taken an influenza antiviral medication in the past 48 hours?	Yes	No
11.	Has your child received a previous Seasonal Flu vaccine **THIS** flu season?	Yes	No
	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.

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