 **FLUMIST**

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**SEASONAL FLUMIST PATIENT QUESTIONNAIRE 2025-2026 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
3. If Yes, has your child received 2 or more doses of the Flu vaccine Yes No

prior to July 1, 2025?

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. Has your child had any previous reaction/problem with Flu vaccines? Yes No

1. Has your child had a fever within the past 48 hours? Yes No
2. Does your child have a history of asthma, wheezing, or albuterol use? Yes No
3. Does your child have any other metabolic diseases, including diabetes Yes No

or renal dysfunction?

1. Has your child received any other live vaccines (MMR, Varivax or Flumist) Yes No

within the past 4 weeks?

1. Does your child have sickle cell disease? Yes No
2. Has your child taken an influenza antiviral medication in the past 48 hours? Yes No
3. 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

Revised 07/10/2025HSE