

Ellicott City Pediatric Associates PA

Office use

TEMP: _____ COVID SCREEN: _____

Patient Name: _____

Visit Date: _____

Date of Birth: _____

Age: _____

Flu Vaccine Questionnaire

1. Is this the **first** flu vaccine this patient has **ever** received?
2. Has the patient received any flu vaccine **this flu season (August-May)**?
3. Is the patient allergic to eggs, Neomycin, gelatin, thimerosal or Arginine?
4. Has the patient ever had a serious reaction to the flu vaccine?
5. Does the patient have an immune deficiency such as: cancer, HIV/AIDS, on chemotherapy or radiation, on long-term steroids, on immune suppressing medications, or on aspirin therapy, and been advised not to have any vaccinations?
6. Is the patient pregnant OR breastfeeding?
7. Have you ever been told your child has Guillian-Barre'?
8. Is the patient **sick** today?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

By signing this form, I give permission to be vaccinated and agree that the above information is correct. I have been offered the *Vaccine Information Sheet (08/06/2021)* and had my questions answered.

***NOTE: FLU MIST IS UNAVAILABLE AT ECPA FOR THIS FLU SEASON.**

Signature: _____ (patient or guardian) Date: _____

** FOR OFFICE USE **

Stock : VFC / REG (circle one)

Lot #: _____

Dose administered: _____

Expiration Date: _____

Where Administered: _____ IM

Reviewed & Administered by: _____ Date: _____

NOTES: _____