FLU QUESTIONS 2025-2026

OFFICE USE ONLY:
VFC Regular

TODAY'S DATE: _____/_____/_____

PATIENT'S NAME: _____ Date of Birth: ____/____ /_____ AGE: _____
(Each patient needs a separate sheet)

Has this patient had any:

1.	Previous flu vaccine? (2 doses 1 mo apart if 1st time getting flu vaccine + under 9)	1. No	Yes
2.	Illness or fever in the last 24 hours?	2. No	Yes
3.	Allergy to EGG or NEOMYCIN?	3. No	Yes
4.	Severe reaction to previous flu vaccine? (e.g. Prolonged fever)	4. No	Yes
5.	Other vaccines (shots) in the last 4 weeks?	5. No	Yes
6.	Oral (by mouth) steroids (Prednisone), radiation treatment, anti-cancer medication or anti-viral medicine (Tamiflu, Relenza, Peramavir, Baloxavir) in the past 3 months or a blood transfusion.	6. No	Yes

****

WHICH IMMUNIZATION IS THIS PATIENT GETTING TODAY? (PLEASE CIRCLE ONE)

Under 2 years old	Over 2 years old **SHOT**	Over 2 years old **MIST**
(**only shot**)	(shot in arm)	(squirt up nose)

****

Most insurance companies do pay for flu vaccine for children, but Valley Pediatrics cannot guarantee that.

I am aware **my insurance may not pay for this Flu vaccine.** If my insurance company does not pay for this vaccine, I realize I am responsible for the cost, which is $50.00 + administration fee.

PARENT'S SIGNATURE: **X**_____ **Date:** _____/_____/_____

MA Initial: _____