



## Metropolitan Pediatrics Flu Vaccine Questionnaire

	Yes	No
1) Has your child ever had a history of a severe allergic reaction to eggs or a serious reaction to a previous dose of influenza vaccine?	_____	_____
2) Does your child have a history of Guillain-Barre Syndrome?	_____	_____
3) Is your child under the age of 6 months?	_____	_____
4) Is your child currently taking aspirin?	_____	_____
5) Does your child have a possible immune deficiency?	_____	_____
6) Does your child have a history of asthma, heart disease, kidney disease, diabetes, or a disease of the lungs, liver, nerves or blood? Has your child needed albuterol or had wheezing in the past 12 months?	_____	_____
7) Does your child live with anyone who is immunosuppressed?	_____	_____
8) Is your child severely congested, or has he/she had a fever over 100.5 in the past 2 days?	_____	_____
9) Is your child under the age of 2?	_____	_____
10) Has your child received the <u>MMR</u> vaccine, the <u>Varicella</u> (chicken pox), <u>Rotavirus</u> or the <u>Flu-Mist</u> vaccine within the past 4 weeks?	_____	_____
11) Has your child received anti-viral medication in the past 48 hours?	_____	_____
12) Is your child pregnant?	_____	_____

If you answered “yes” to question #1, #2 or #3, your child should NOT receive either the Flu-Mist (intranasal), or the Flu-Zone (“the flu shot”).

If you answered “yes” to any of the questions #4 through #12, but “no” to questions #1, #2, and #3, your child should NOT receive the Flu-Mist (nose-spray), but may receive Flu-Zone (“the flu shot”).

The booster dose for all flu vaccines should be approximately 4 weeks apart.

Which vaccine are you requesting?

\_\_\_\_\_ Flu shot

\_\_\_\_\_ Flu Mist

**Patient Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Parent’s Signature** \_\_\_\_\_