Four Seasons Pediatrics Seasonal Flu Vaccine Questionnaire

Patient Name: **Date of Birth:**
Vaccine Preferred (Place an X) ☐ **Seasonal Flu Shot** ☐ **Seasonal Nasal Spray (FluMist)**

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child an influenza vaccination today. If you answer ñyesò to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked.

Answer the following questions regardless of which vaccine you will be receiving:

Is the person to be vaccinated sick today? ☐ No ☐ Yes
(Note a mild illness does not preclude vaccination)

Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? ☐ No ☐ Yes
(If yes, we need an ok from your allergist to get the vaccine)

Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ No ☐ Yes
(If yes, what type of reaction?)

Has the person to be vaccinated ever had Guillain-Barr®syndrome? ☐ No ☐ Yes
(If yes we need to discuss risk benefit of the vaccine)

Answer the following questions if receiving the nasal spray (Flu Mist):

Is the person to be vaccinated younger than age 2 years or older than age 49 years? ☐ No ☐ Yes
(If no, initial here to indicate you request off label use if approved)

Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, moderate to severe asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder? ☐ No ☐ Yes
(If yes, you must receive the shot instead of the nasal spray)

Does the person to be vaccinated have mild or inactive asthma?
(If yes, I acknowledge that the Flu Mist can be given with asthma but may cause some asthma like symptoms. Studies show this is not likely to cause any change in asthma Treatment – Initial Here) ☐ No ☐ Yes

Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs? ☐ No ☐ Yes
(If yes, you must receive the shot instead of the nasal spray)

Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy? ☐ No ☐ Yes
(If yes, you must receive the shot instead of the nasal spray)

Is the person to be vaccinated pregnant or could she become pregnant within the next month? ☐ No ☐ Yes
(If yes, you must receive the shot instead of the nasal spray)

Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (such as in a hospital room with reverse air flow)? ☐ No ☐ Yes
(If yes, you must receive the shot instead of the nasal spray)

Has the person to be vaccinated received any other vaccinations in the past 4 weeks? ☐ No ☐ Yes
(If MMR, Varicella, Flu Mist or Yellow Fever was given in the last 4 weeks, you must receive the shot or wait 4 weeks from the date of vaccination to get the Flu Mist)

Has the person to be vaccinated received Tamiflu or Relenza in the past 48 hours? ☐ ***No*** ☐ ***Yes***
(If yes, you must wait 48 hours before getting the Flu Mist)

☐ ***I have reviewed the Vaccine Information Statement Online and do not need a copy (GO GREEN)***
☐ ***I would like a paper copy of the Vaccine Information Statement***