Four Seasons Pediatrics
Seasonal Flu Vaccine Screening Form

Patient Name: _____Date of Birth: _____
Full name of Parent who is in car: _____ Appointment TIME: _____ AM

If you answer YES to any of the following symptoms, please reschedule your appointment unless you have a negative PCR test during this illness. This is for the safety of our staff. If any of your responses change before coming to the office, PLEASE CALL US IMMEDIATELY AND DO NOT ATTEND THE FLU CLINIC OR ENTER THE BUILDING. Thank you for your cooperation.

1. Please indicate if anyone coming for your appointment is having any of the following symptoms:
   - ☐ Fever
   - ☐ Cough
   - ☐ Difficulty Breathing
   - ☐ Runny Nose
   - ☐ Diarrhea
   - ☐ Vomiting
   - ☐ Sore Throat
   - ☐ Body Aches
   - ☐ Loss of taste or smell (new)
   - ☐ Chills or repeated shivering (new and repeating)
   - ☐ No symptoms

2. Is anyone (coming for your appointment) aware of any close contact with someone who tested positive for COVID-19 in the past 10 days?
   - ☐ Yes
   - ☐ No

TURN OVER FOR SIDE 2 →

Patient Name: _____DOB: _____

Current Allergies: _____ Temp by Staff: _____

PATIENT is: ☐ Driver ☐ Fro Pass Side ☐ Rear Driv Side ☐ Rear Pass Side ☐ STAFF VERIFIED

Flu Vaccine Screener – PLEASE PUT CAR IN PARK AT EACH TENT

Has the patient ever had a serious reaction to the flu vaccine in the past? *If yes, what type of reaction?*	___**Yes** ___No
Has the patient ever had Guillain-Barre syndrome? *If yes, we need to discuss the risk benefit of the vaccine, (NOT REC IF GBS WITHIN 6 weeks of previous vaccine)*	___**Yes** ___No

IF YOU ARE REQUESTING THE FLU MIST, please ALSO answer the questions below

Is the patient under 2 or older than 49?	___**Yes** ___No
Does the patient have a long-term health problem with (heart, lung, kidney, neurologic neuromuscular, liver or metabolic) disease, moderate to severe asthma, anemia or another blood disorder? *If yes, you can only receive the injection vaccine.*	___**Yes** ___No
Does the patient have asthma or has been seen for wheezing in the last 12 months? *If yes, we generally recommend the flu shot)*	___**Yes** ___No
Does the patient have a weakened immune system due to any disease, long term medications or cancer medications or treatment? *If yes, you can only receive the injection vaccine.*	___**Yes** ___No
Is the patient receiving aspirin therapy? *If yes, you can only receive the injection vaccine.*	___**Yes** ___No
Females: Is the patient pregnant or could become pregnant within the next month? *If yes, you can only receive the injection vaccine.*	___**Yes** ___No
Does the patient live with or have contact with a person that has a weakened immune system and must be in a protective environment? *If yes, you can only receive the injection vaccine.*	___**Yes** ___No
Has the patient received the MMR, Varicella, FluMist or Yellow fever vaccination within the last 4 weeks? *If yes, you can only receive the injection vaccine OR wait 4 weeks from the date of that vaccination.*	___**Yes** ___No
Has the patient received the medications Tamiflu or Relenza in the past 48 hours? *If yes, you must wait until 48 hours to get the FluMist.*	___**Yes** ___No

PLEASE SELECT ONE OF THE BELOW

_____I have reviewed the Vaccine Information Statement online do not need a copy

_____I would like a paper copy of the Vaccine Information Statement to take home

_____ **Signature of responsible party**

_____ **Printed name and relationship**

_____ **Today's Date** _____

STAFF USE: ☐ SHOT ☐ MIST ☐ Comm ☐ VFC ☐ Given by:_____
Loc: ☐ RD ☐ LD ☐ RT ☐ LT ☐ Nasal
Lot Number:_____
If vaccine given to driver - time given they can leave:_____