Pediatric Junction, PA

Keeping children's health on the right track!

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ADULT NON-PATIENT
FLU VACCINE SCREENING QUESTIONNAIRE

Date: ______________________

Name:____________________________________ **DOB:** _______________

***** Payment for the vaccine is due at the time of service. Price: $35***

		Yes	No
1.	Have you had a SEVERE allergy (anaphylaxis or hives) to GELATIN or ever had a SERIOUS REACTION to any vaccine or its components?		
2.	Are you able to eat lightly cooked eggs (scrambled, for example) without a reaction? If No: ▪ Is the reaction only hives? YES NO ▪ Is the reaction severe (cardiovascular and respiratory symptoms)? YES NO **Ask for a Flu Vaccine & Egg Allergy Info sheet for more information.**		
3.	Have you ever had Guillain-Barre syndrome (A condition in which the immune system attacks the nerves. Paralysis may occur.) within 6 wks of receiving any flu vaccine?		
4.	Are you moderately or severely ill?		
5.	Have you had previous problems with the flu vaccine?		
	ANSWER THESE ADDITIONAL QUESTIONS IF YOU ARE GETTING FLU MIST TODAY **(FluMist is a live, intranasal Flu Vaccine)**		
	If answering YES to any questions, you will NOT be able to get FluMist.	**Yes**	**No**
6.	Are you 50 years of age or older?		
7.	Do you have any chronic problems (diabetes, asthma, seizure disorder)?		
8.	Are you pregnant or could you become pregnant in the next 4 weeks?		
9.	Are you taking any antiviral medications such as Tamiflu or Relenza? *FYI: If you receive FluMist today and begin a course of antiviral therapy within 2 weeks AFTER receiving the FluMist, you should be REVACCINATED.*		
10.	Are you IMMUNOSUPPRESSED (have HIV/AIDS, undergoing chemotherapy, on high-dose course of steroids)? Do you live with or have close contact with such a person?		

By signing below, I attest that the above information is true and correct and I have reviewed the vaccine information sheet. I am choosing to pay out-of-pocket for my vaccine and agree to not use my insurance benefits for the flu vaccine. No insurance will be filed by Pediatric Junction.

____
Signature and Date

FOR INTERNAL USE ONLY:

DOSE GIVEN:

0.5mL IM Influenza vaccine

R L DELTOID
Lot#
Exp:

FluMist – (Manufacturer:Medimmune)
Lot#
Exp:

Approved By: ____________________

TOTAL: $_________

PAID BY:______________________

☐ Cash ☐ Credit/Debit ☐ Check

COLLECTED BY:__________________

____
Staff Signature and Date

VIS GIVEN – 8/7/2015
LAST UPDATED 9/17/2015