BEITTEL-BECKER PEDIATRIC ASSOCIATES
2150 Noll Drive, Suite 100
(717)299-8933 FAX: (717)299-5635
D Brown DO G Laube MD
B Martin PA-C A Funk Sweigart CRNP

Flu Shot Visit
Parent/Guardian

Adults Name: **DATE OF BIRTH:** **Age:**

Does the above listed person have…?

☐ Yes ☐ No A serious allergy to eggs or egg products?

☐ Yes ☐ No A fever over 101°?

☐ Yes ☐ No A past severe reaction to the flu shot?

☐ Yes ☐ No A history of Guillain Barre Syndrome?

☐ Yes ☐ No Taking an aspirin regimen prescribed by a doctor?

☐ Yes ☐ No Taking a medication prescribed by a doctor List: _____

☐ Yes ☐ No Contact with a transplant patient?

☐ Yes ☐ No Asthma requiring medicine in last year?

☐ Yes ☐ No Chronic Illness such as: heart disease, diabetes, kidney disease, immune system, or hemoglobin disorder,
Other: _____?

☐ Yes ☐ No Are you pregnant or breastfeeding?

☐ Yes ☐ No Received the MMR or Chicken Pox vaccine in the last month?

I have read and I understand the information given to me, including the Vaccine Information Statement (VIS). I have had a chance to ask questions, which were answered to my satisfaction. I believe that I understand the benefits and risks of taking the flu vaccine, and I request that the vaccine be given to me or to the person named for whom I am authorized to sign. I also understand that Beittel-Becker Pediatric Associates will not bill my insurance and that this shot is being provided as a courtesy to me. No receipt of vaccination will be given.

Signature: _____ **Date**: _____

FOR OFFICE USE:

☐ **Flulaval QIV PF 0.5 ml (90686)** ☐ **Flumist QIV PF (90672)**

Administered By: _____

Administered: ☐ LA ☐ RA ☐ Intranasal **Lot #: _____** **Exp: _____**

☐ $40 Fee collected by: _____