

BEITTEL-BECKER PEDIATRIC ASSOCIATES
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D Brown DO G Laube MD S Crooks MD
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Flu Shot Visit Child

Patient Name: _____ DATE OF BIRTH: _____ AGE: _____

Insurance Company: _____ Ins. ID (required if new): _____

Does the above listed Patient 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?
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- ☐ Yes ☐ No Taking aspirin regimen prescribed by a doctor?
- ☐ Yes ☐ No Contact with a transplant patient?
- ☐ Yes ☐ No Asthma requiring medicine in the last month?
- ☐ Yes ☐ No Chronic Illness such as: heart disease, diabetes, kidney disease, immune system, or hemoglobin disorder,
Other: _____?
- ☐ 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.

Signature: _____ Date: _____

FOR OFFICE USE:

☐ **Flulaval QIV PF** ☐ **Flumist QIV PF**
0.5 ml (90656) (90672)

Administered By: _____

Administered: ☐ LA ☐ RA ☐ LT ☐ RT ☐ Intranasal Lot #: _____ Exp: _____

VFC Given: ☐ YES ☐ NO