Pure Joy PEDIATRICS
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Flu Vaccine Form

Child's Name: _____ Date of Birth: ____/____/_____ Age:____

Parent's Name: _____ Date of Birth: ____/____/_____ Age:____

Have you ever had any of the following?

1.	A serious allergic reaction to egg or egg products (hives, swallowing difficulty, tongue swelling, difficulty breathing, shock?)	○ Yes	○ No
2.	A serious allergic reaction to a previous flu vaccine?	○ Yes	○ No
3.	Guillain-Barre Syndrome GBS-a serious neurological condition?	○ Yes	○ No
4.	Do you currently have a fever over 101°F/38.3°C?	○ Yes	○ No
5.	Do you have asthma or have you wheezed in the last 12 months	○ Yes	○ No
6.	Are you taking Aspirin or Aspirin-containing medications daily?	○ Yes	○ No
7.	Are you suspected to be immunocompromised (low immunity to fight diseases)? Or do you care for severely immunocompromised persons who require a protected environment?	○ Yes	○ No
8.	Are you 50 years or older?	○ Yes	○ No
9.	Is there a possibility that you are pregnant?	○ Yes	○ No
10.	Are you asplenic, or with a non-functioning spleen?	○ Yes	○ No
11.	Have you recently had head, neck or brain surgery?	○ Yes	○ No
12.	Do you have cochlear implants?	○ Yes	○ No
13.	Have you taken flu antiviral drugs within a certain amount of time (within the past 48 hours for oseltamivir and zanamivir, the past 5 days for peramivir, and the past 17 days for baloxavir).	○ Yes	○ No

NOTE: IF you answered "**YES**" to any of the above questions we will ask you to consult with your personal physician.

Vaccine given Date: ____/____/_____

_____
Kirin Palmer, MD

Site of vaccine administration:

❍ **LA** ❍ **RA**

❍ **LT** ❍ **RT**

Flu Mist Vaccine:

○ Yes