PEDIATRIC HEALTHCARE ASSOCIATES
INFLUENZA VACCINE QUESTIONNAIRE

CHILD'S NAME: _____ **Date of Birth:** _____

Patient Number:

	YES	NO
Has this child ever received a flu vaccine (shot or mist) ?	____	____
Is this child allergic to eggs?	____	____
Is the child to be vaccinated sick today?	____	____
Is the person to be vaccinated pregnant or could she become pregnant within the next month?	____	____
I have been given the CDC information on Influenza vaccine.(published 8/7/2015)	____	____

We will be submitting a bill for this vaccine to your insurance company. Some companies do not cover this service or only partially. If it is a non-covered item or partially paid, you will be responsible for part or all of the cost of the immunization.

Please date and sign that you have read and accept all of the above.

_____ _____
Parent / Guardian / Patient Date

Administered & reviewed by:_____ Site: _____

Revised 8/3/16