

**PATIENT Request for Flu Vaccine**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Parent/Guardian, please date, complete Section I and sign.*

Flu Mist is available for patient 2 years and older, who meet the criteria

**SECTION I:** Please print clearly

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

- |  |      |      |
|--|------|------|
| 1. Has the patient had a flu shot or mist before?                        | Yes  | No   |
| 2. If so, which did they have?   | Shot | Mist |
| 3. Is the patient sick today?  | Yes  | No   |
| 4. Is the patient allergic to eggs?                                      | Yes  | No   |
| 5. Does the patient take regular asthma medication?                      | Yes  | No   |
| 6. Is anyone in your household (including caregivers) immune suppressed? | Yes  | No   |
| 7. Does the patient have a chronic medical condition?                    | Yes  | No   |
| 8. Is there a possibility the patient could be pregnant?                 | Yes  | No   |

Your insurance may or may not cover this vaccine. You will be responsible for any non-covered service.

Signature: \_\_\_\_\_  
Parent/Guardian or Patient 18 yrs and older

**SECTION II: (OFFICE USE ONLY)**

\_\_\_\_\_ Immunization informed consent/counseling

Flu Mist nasal spray \_\_\_\_\_ Lot #

Flu Vaccine PF \_\_\_\_\_ Lot #

Flu Vaccine > 3 yr \_\_\_\_\_ Lot #

M.D./R.N. Signature \_\_\_\_\_

Please initial:

\_\_\_\_\_ Posted

\_\_\_\_\_ Logged on flow sheet & filed in chart