

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 ____/____/____

Circle one:

Complete only if your child is 6 months to 8 years of age:

- 1. For patients 6 months of age through 8 years old:
 - a. did the patient have H1N1 vaccine 1st year? Yes No
 - b. has the patient ever received seasonal influenza vaccine? Yes No Not Known
 - c. was last year the child's first to receive seasonal influenza vaccine? Yes No Not Known
 - d. did the patient receive 2 doses of influenza vaccine last year? Yes No
- (If your child needs a 2nd dose of flu vaccine one of our nurses will call you.)

For All Patients:

- 1. Has the patient had a fever of 100.4 or greater in the past 24 hours? Yes No
- 2. Is the patient allergic to eggs? Yes No
- 3. Does the patient take regular asthma medication? (frequent wheezing or use of controller medications such as Flovent, Pulmicort, or Advair) Yes No
- 4. Is anyone in your household, including caregivers, severely immunosuppressed? (SEE CDC FAQ for clarification) Yes No
- 5. Does the patient have a chronic medical condition? Yes No
- 6. For older girls, is there a possibility she could be pregnant? Yes No
- 7. **If the office needs to contact you, what is the best daytime number?** _____

Most insurances pay for this vaccine. If not, 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

Unknown status:
 _____ Chart check needed to verify # of doses
 Family notified on _____ & initial _____