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. has the patient ever received seasonal influenza vaccine? Yes No Not Known
   b. did the patient receive 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, Quar, 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______