Mid City Pediatrics

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Patient Information

Please complete entire form - One form for each child.

Child's Name: _____ D.O.B: _____ Age: _____ Today's Date: _____

Address: _____ Physician: _____ Time: _____

_____ Insurance Co: _____

Phone Number: _____

***If the answer to question 1 or 2 below is yes, your child will *NOT* be able to receive their flu vaccine until they are well or the quarantine is over.**

1. Does your child have exposure to COVID-19 and/or symptoms of, suspected or confirmed COVID-19?*	**YES**	**NO**
2. Does anyone present in the car have exposure to, symptoms of, suspected or confirmed COVID-19?*	**YES**	**NO**
3. Has any of the above information changed since the last visit?	**YES**	**NO**

Flu vaccine screening questionnaire

Please circle yes or no for each question

Is your child less than 6 months old?	**Yes**	**No**
Has your child ever had an allergic reaction to any vaccine?	**Yes**	**No**
Has your child had an allergic reaction to latex?	**Yes**	**No**
Has your child had a severe allergic reaction to eggs?	**Yes**	**No**
Has your child ever had Guillian-Barre' disease?	**Yes**	**No**
Did your child receive a flu shot or nasal flu vaccine last year?	**Yes**	**No**

Some children age 6 months to 8 years of age will require 2 doses of flu vaccine. Children in this age group getting vaccinated for the first time, and those who have only previously gotten one dose of vaccine, should get two doses of vaccine this season—spaced at least 4 weeks apart.

A copy of the appropriate Center for Disease Control and Prevention Information Statement has been provided. I have read, or had explained, information about influenza and the flu vaccine. I had the opportunity to ask questions and my questions were answered satisfactorily. I believe that I understand the risks and benefits of the vaccine ci be given to my child, named above, for whom I have the leg est.

Signature of parent or guardian: _____ _____

For office use only:

Temp: _____

Fluarix PF 0.5

Time: _____

Lot # _____

Site: _____

Expiration date _____June 30, 2024_____

Given by: _____

Physician signature: _____