

Mid City Pediatrics

2225 Line Avenue, Shreveport, LA 71104 318-221-2225

Scott E. Ritch, M.D.
Jennifer P. Cockrell, M.D.

Angela Cush-John, M.D.
Gretchen G. Petterway, M.D.
Bryan L. Roberts, M.D.

David J. Pace, M.D.
Elle F. Ratliff, M.D.

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: _____

Flu vaccine screening questionnaire

Please circle yes or no for each question

Has your child had a fever greater than 100.4 in the last 24 hours?	Yes	No
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 cited, and request this vaccine be given to my child, named above, for whom I have the legal authority to make this request.

Signature of parent or guardian: _____

For office use only:	Temp: _____
Fluarix PF 0.5	
Time: _____	Lot # _____ N737Y
Site: _____	Expiration date _____ June 30, 2025
Given by: _____	
Physician signature: _____	