

Child's Name: _____ DOB: ____/____/____

Flu Questionnaire for Children

	Yes	No	Don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lungs, heart, kidney disease, metabolic disease (such as diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told that your child has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past three months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consent:

Parent Signature _____

Date _____

Parent Name Printed _____

Nursing Use Only:

<u>Vaccine Name:</u>	<u>Date Administered</u>	<u>Lot Number</u>	<u>Exp. Date:</u>	<u>Manufacturer:</u>	<u>Site Administered:</u>	<u>Administered By:</u>

Insurance Information:

Insurance Type: MaineCare Anthem Cigna Community Health Options Medicare Harvard Pilgrim United Healthcare Aetna

Other: _____

Primary Care Provider: _____

Policy Number: _____

Group Number: _____