Pediatric/Adolescent 2011-2012 Seasonal Influenza Vaccination Form

PRIVACY ACT STATEMENT: This form contains sensitive Personally Identifiable Information (PII), protected under the Privacy Act which is FOR OFFICIAL USE ONLY and must be protected in accordance with the Privacy Act, 5 USC § 552a. Unauthorized disclosure or misuse of the sensitive PII may result in criminal and/or civil penalties.

PLEASE PRINT LEGIBLY

Patient's full name:_____ Patient's SSN:_____ Patient's birth date:_____

Sponsor's full name:_____ Sponsor's SSN:_____ Sponsor's birth date:_____

Other Health Insurance Company: _____ E-mail address (for survey):_____

FOR CHILDREN IN SCHOOL OR DAY CARE

Grade: _____ Name of school or day care:_____

Your answers to the questions below help us determine if there is a reason we should not vaccinate your child against influenza. A "YES" answer to a question does not necessarily mean your child should not be vaccinated. It may mean we must ask more questions. Please ask the healthcare provider to explain any question you do not fully understand.

1	Has your child ever received the seasonal flu vaccine?		YES	NO
2	Has your child ever had a serious reaction to any vaccine?		YES	NO
3	Does your child have an allergy to eggs, egg protein, monosodium glutamate (MSG), gentamicin, neomycin, polymyxin, gelatin, arginine, thimerosol, formaldehyde, latex, or ANY other vaccine components?		YES	NO
4	Does your child have a history of Guillain-Barre syndrome (GBS)?		YES	NO
5	Is your child sick with a fever today?		YES	NO
If your child is younger than 2 years of age, SKIP questions 6-13.				
6	Does your child have a history of asthma, reactive airway disease or wheezing?		YES	NO
7	Does your child have a history of heart, lung, kidney, metabolic (diabetes for example), or blood disease, cochlear implants, or ANY other life-long health condition?		YES	NO
8	Does your child have a weakened immune system, take long-term high-dose steroid treatment, or take cancer treatments?		YES	NO
9	Is your child currently taking any prescription medications to prevent or treat the flu?		YES	NO
10	Has your child taken any prescription medications to prevent or treat the flu in the last 48 hours?		YES	NO
11	Will your child have close contact with a severely immunocompromised person (one who must be kept in a protective environment, like organ transplant recipients)?		YES	NO
12	Is the adolescent to be vaccinated pregnant?	Does not apply	YES	NO
13	Has your child received any vaccines within the last 30 days or is going to receive any other vaccine within the next 4 weeks?		YES	NO
14	Please list all the medications your child is currently taking: (for medication reconciliation).			

CONSENT FOR CHILD'S VACCINATION: My signature below means that I give permission/consent to have my child vaccinated. I have read, had access to, or had explained to me the information contained in the 2011-2012 Influenza Vaccine Information Sheet. I had the opportunity to ask questions, and I understand the benefits and risks of the influenza vaccine.

Signature:_____ Date:_____

BELOW TO BE COMPLETED BY A HEALTH CARE PROVIDER.				**DATE:**		
Type and route	Dose	Site	Manufacturer	Lot number	Interviewer Signature	Vaccinator Signature
☐ Inactivated IM Injection 6-35 months (PEDI FLUZONE)	0.25 mL	**6-12 months** Thigh L or R / **> 12 months** Deltoid L or R	Sanofi-Pasteur			
☐ Inactivated IM Injection ≥ 35 months (FLUZONE)	0.5 mL	Deltoid L or R	Sanofi-Pasteur			
☐ Live Intranasal ≥ 2 years old (FLUMIST)	0.2 mL	Nasal	Sanofi-Pasteur			
☐ Pneumococcal IM (PCV13 or PPSV)	0.5 mL	Deltoid L or R	Wyeth-PCV13 Merck - PPSV			
☐ No vaccine given today						

Notes: