

Inactivated Influenza Vaccine Questionnaire

Please answer the following questions about your child.

Child's Name

Date of Birth

1. Does your child have an allergy to chicken eggs or egg products? Yes No
2. Has your child ever had an allergic reaction to the influenza vaccine? Yes No
3. Does your child currently have a fever or is severely ill? Yes No
4. Does your child have a history of Guillain-Barré Syndrome? Yes No
5. My child is under 9 years old AND getting the influenza vaccine for the very first time in his/her life, or received the influenza vaccine last year for the very first time and only received one shot. Yes No
 I don't know
I understand that if the above statement is true, my child will need two influenza vaccines this year. I will schedule an appointment for the second dose one month later.
6. I have read and understand the information on the vaccine information statement provided and would like my child to receive the influenza vaccine. Yes No

Signature of or Parent/Guardian

_____ Date _____

Reviewed by _____, M.A, R.N, M.D.