PATIENT Request for Flu Vaccine

Today's Date: _____

Parent/Guardian, please date, complete Section I and sign.

SECTION I: Please print clearly.

Patient Name_____ DOB_____ Circle One:

Complete only if your child is 6 months to 8 years of age:

1. For patients 6 monthd through 8 years old:
   a. Has the patient ever received seasonal influenza vaccine? Yes No Unknown
   b. Has your child received 2 doses of flu vaccine before July 1, 2018? Yes No Unknown

For All Patients:

1. Has the patient had a fever of 100.4 or greater in the past 24 hours? Yes No
2. Is the patient allergic to eggs? Yes No
3. Does the patient take regular asthma medication? (Frequent wheezing or use of controller medications such as Flovent, Pulmicort QVar, or Advair). Yes No
4. Is anyone in your household, including caregivers, severely immuno-suppressed? Yes No
5. Does the patient have a chronic medical condition or had Guillain-Barre Syndrome in the past? Yes No
6. For older girls, is there a possibility she could be pregnant? Yes No
7. **If the office needs to contact you, what is the best daytime number? _____**

Lamorinda Pediatrics has been in contact with your insurance regarding payment, however many have not confirmed whether they will pay for this vaccine. If your insurance does not cover the flu vaccine, the cost will be reduced to $50 per dose.

Signature: _____

Parent/Guardian or patient 18 yrs and older

SECTION II: (OFFICE USE ONLY)

_____ Immunization informed consent/counseling

Flu Vaccine 6-35 mo _____

Flu Vaccine >3 yr _____

Flumist _____

Please initial:

_____ Posted