Office Children Flu- Screening Questionnaire

Name:____________________________ Date of Birth ____/___ /____ Age:_____ Male or Female
Address:____Zip:________ Phone:________________

Ages 6 months to 18 years old

The following questions help us determine which vaccines your child may be given today

		Yes	No	Unsure
1	Has your child received a flu vaccination before?			
2	Did your child receive the H1N1 vaccination last year?			
3	Has the patient received vaccinations in the past 4 weeks? If yes, name vaccine:			
4	Does the child have an allergies to any part of the flu vaccine (eggs, gentamycin, gelatin, arginine) ?			
5	Has your child ever had a life threatening reaction to an influenza vaccine?			
6	Is your child sick today? Fever?			
	If getting the Flu Mist, please answer questions 7-11			
7	Does you child have any of the following long-term health problems? (Check) ☐ heart disease ☐ kidney disease ☐ metabolic disease (for example, diabetes) ☐ Blood disorder ☐ long term aspirin therapy Other______________________________ **Please ask your child's Dr. if they have any of these conditions.**			
8	Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take any medication that lowers the body's resistance to infection (such as steroids or chemo)?			
9	If female, is the patient pregnant?			
10	Does your child have **asthma** or recurrent wheezing?			
11	Does your child have close contact with anyone who has a weakened immune system?			

I have received VIS forms and I understand the risks and benefits, side effects and warnings of influenza vaccine. I give permission to administer the Flu vaccine for the above named recipient.
If IDPA, I hereby authorize FCHD to release information related to this claim and authorize payment directly to FCHD and I understand I am responsible for payment if Medicaid does not reimburse for the immunization. This an acknowledgment that they have received a copy of the "Joint Notice of Privacy Practices" dated March 17, 2003, and have been given the important information sheet from the health department.

Parent/Guardian Signature:____Date:___________________________

=========FCHD USE ONLY=========

Administer- Flu VIS 8/2010 2010-2011 Formula
Mist Or Shot
Man- _________________________
Lot # _________________________
Nurse Signature____ Date:__________________

Payment Amount= $23.00 cash or check
or Medical Card:_______________________

Fayette County Health Department, 509 W. Edwards St, Vandalia, IL