

Pediatric Health Associates, P.C.
FLU VACCINE HISTORY- Intranasal Influenza Vaccine
FOR NON-PHYSICIAN VISIT

Name: _____ Date: _____ DOB: _____ Age: _____

Street Address: _____, City: _____, Zip: _____

Allergies: _____ Current Medications: _____

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (LAIV, FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

- | | | |
|--|-----|----|
| 1. Is the person to be vaccinated sick today? | YES | NO |
| 2. Does the person to be vaccinated have an allergy to a component of the influenza vaccine? | YES | NO |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | YES | NO |
| 4. Is the person to be vaccinated younger than age 2 years or older than age 49 years? | YES | NO |
| 5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen? | YES | NO |
| 6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma? | YES | NO |
| 7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken , medications that affect the immune system (e.g., prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs) or have they had radiation treatments? | YES | NO |
| 8. Is the person to be vaccinated receiving influenza antiviral medications? | YES | NO |
| 9. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine? | YES | NO |
| 10. Is the person to be vaccinated pregnant or could she become pregnant within the next month? | YES | NO |
| 11. Has the person to be vaccinated ever had Guillain-Barré syndrome? | YES | NO |
| 12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? | YES | NO |
| 13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? | YES | NO |

Signature

Date

90672 - FluMist: Lot# _____ **Exp:** _____ **Diagnosis Code = Z23**

Date Administered: _____

By: _____