Pediatric Health Associates, PLLC

FLU VACCINE HISTORY
FOR NON-PHYSICIAN VISIT

Parents Must Complete the Following:

Name ______________________________ Date: ______________
Street Address ________________________________, City ____________________, Zip __________
DOB __________/______/______ Age _____ Phone # ______________________

Allergies: __________________________ Current Medications: _________________________

Diagnosis Code = Z23

1. Have you ever had:
   - A serious allergic reaction to egg or egg products (hives, swelling of the lips or tongue, difficulty breathing, shock)? YES NO
   - A serious allergic reaction to a previous flu vaccine? YES NO
   - Guillain-Barré Syndrome GBS – a serious neurological condition. YES NO
2. Are you currently sick ? YES NO
3. Do you have asthma? YES NO
4. Are you taking Aspirin or aspirin-containing medications? YES NO
5. Are you known or suspected to be immunocompromised (low immunity to fight diseases?) YES NO
6. Is there any possibility that you are pregnant or breastfeeding? YES NO

N/A

If you have answered "yes" to any of the above questions the clinical staff member must consult with a physician and obtain a specific written order before the vaccine can be administered.____

______________________________ ____________________
Signature Date

90686 - Flu Shot: Sanofi Pastuer – **Preservative Free** Product **Lot#**_______________ **Exp.**________

90688 - Flu Shot: Sanofi Pastuer –**MULTIDOSE** Product **Lot#**_______________ **Exp.**__________

90672 – Flu Mist: MedImmune – **Product Lot#** ___________________ **Exp.** ____________________

Date Administered:______________________ **By:** ________________________

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