Goodlettsville PEDIATRICS

2018-2019 INFLUENZA

Name of person receiving vaccine: _____

Date of Birth: _____

Age: _____

Flumist:

Flu shot:

Flumist must between age of 2-49

Have you had ANY vaccines in the past 30 days?	Yes ◯	No ◯
Are you allergic to chicken or eggs?	Yes ◯	No ◯
Are you pregnant?	Yes ◯	No ◯
Do you have lung disease, diabetes, kidney disease or heart disease?	Yes ◯	No ◯
Do you have any immunocompromising conditions such as HIV or cancer, are you on chemotherapy medications?	Yes ◯	No ◯
Do you take aspirin on a regular basis?	Yes ◯	No ◯
Have you had Guillain-Barre syndrome?	Yes ◯	No ◯

Flu Injection 6 months and older

Have you ever had any reaction to flu vaccine?	Yes ◯	No ◯
Have you had Guillain-Barre syndrome?	Yes ◯	No ◯

Please circle if wanting to receive shot or mist

Parent signature: _____

Date:_____

Lot #: