

**Ballard Pediatric Clinic  
Influenza Screening Questionnaire  
2010-2011 Influenza Season**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

***This form MUST be completed BEFORE your child receives a flu vaccination.***

**I am requesting that my child be vaccinated with:**

\_\_\_\_\_ **Flu Shot**

\_\_\_\_\_ **Flu Mist**

**Please answer the following questions:**

Is your child over 6 months of age? **Yes / No** (for Flu Shot)

Is your child 2 years old or older? **Yes / No** (for Flu Mist)

Does your child have asthma / wheezing / reactive airway disease? **Yes / No**

Does your child have any chronic pulmonary, cardiovascular, metabolic or immune disorder? **Yes / No**

Has your child ever had an allergic reaction to a prior flu vaccination? **Yes / No**

Has your child ever had an allergic reaction to eggs? **Yes / No**

Has your child ever been diagnosed with Guillain-Barre syndrome? **Yes / No**

If applicable: Is your adolescent child pregnant? **Yes / No**

I have been provided with a copy of the Vaccine Information Statement. I understand the risks and benefits of this immunization and wish to proceed.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date