Four Seasons Pediatrics Seasonal Flu Vaccine Screening

Patient Name: _____ DOB: _____

Current Allergies: _____ Temp by Staff: _____ ☐ Screening done online

PATIENT is: ☐ Driver ☐ Fro Pass Side ☐ Rear Driv Side ☐ Rear Pass Side ☐ STAFF VERIFIED

2024-2025 Flu Vaccine Screener – PLEASE PUT CAR IN PARK AT EACH TENT

Has the patient ever had a serious reaction to the flu vaccine in the past? *If yes, what type of reaction?*	☐ **Yes** ☐ No
Has the patient ever had Guillain-Barre syndrome? *If yes, we need to discuss the risk benefit of the vaccine, (NOT REC IF GBS WITHIN 6 weeks of previous vaccine)*	☐ **Yes** ☐ No

IF YOU ARE REQUESTING THE FLU MIST, please ALSO answer the questions below

Is the patient under 2 or older than 49?	☐ **Yes** ☐ No
Does the patient have a long-term health problem with (heart, lung, kidney, neurologic neuromuscular, liver or metabolic) disease, moderate to severe asthma, anemia or another blood disorder? *If yes, you can only receive the injection vaccine.*	☐ **Yes** ☐ No
Does the patient have asthma or has been seen for wheezing in the last 12 months? *If yes, we generally recommend the flu shot)*	☐ **Yes** ☐ No
Does the patient have a weakened immune system due to any disease, long term medications or cancer medications or treatment? *If yes, you can only receive the injection vaccine.*	☐ **Yes** ☐ No
Is the patient receiving aspirin therapy? *If yes, you can only receive the injection vaccine.*	☐ **Yes** ☐ No
Females: Is the patient pregnant or could become pregnant within the next month? *If yes, you can only receive the injection vaccine.*	☐ **Yes** ☐ No
Does the patient live with or have contact with a person that has a weakened immune system and must be in a protective environment? *If yes, you can only receive the injection vaccine.*	☐ **Yes** ☐ No
Has the patient received the MMR, Varicella, FluMist or Yellow fever vaccination within the last 4 weeks? *If yes, you can only receive the injection vaccine OR wait 4 weeks from the date of that vaccination.*	☐ **Yes** ☐ No
Has the patient received the medications Tamiflu or Relenza in the past 48 hours? *If yes, you must wait until 48 hours to get the FluMist.*	☐ **Yes** ☐ No

PLEASE SELECT ONE OF THE BELOW

☐ I have reviewed the Vaccine Information Statement online do not need a copy

☐ I would like a paper copy of the Vaccine Information Statement to take home

_____ **Signature of responsible party**

_____ **Printed name and relationship**

_____ **Today's Date**

STAFF USE: ☐ SHOT ☐ MIST ☐ Comm ☐ VFC ☐ Given by:_____
Loc: ☐ RD ☐ LD ☐ RT ☐ LT ☐ Nasal
Lot Number:_____
If vaccine given to driver - time given they can leave:_____ **Updated 09/06/2024**