



2020-2021 FLU VACCINE SCREENING AND CONSENT

Patient Name: _____

Allergies: _____ Known Latex Allergy? () Yes () No

DOB: _____ Age: _____

Accompanied to Visit by: _____

Name and Relationship to Child

YES	NO	Flu Screening Questions
		Have you (your child) had a fever over 100 in the last 24 hours?
		Have you (your child) had a recent cold or any infections?
		Have you (your child) had a reaction to a previous flu vaccine?
		Are you (your child) currently on any medications?

YES	NO	Covid Screening Questions
		Has your child been exposed to anyone with known Covid 19? If so how long ago?
		Do you (your child) currently have any cold symptoms (especially fever or cough)?
		Have you (your child) traveled in the past 2 weeks? If so where?
		In the past 10 days have you (your child) had a temp over 100?
		Has your child within the past 10 days had a cold or any other infections?

**** Please note that any 'yes' response, a provider needs to be consulted.**

Consent

I have been provided a copy of and have read the Influenza Vaccine Information Sheet [VIS]. I have answered the Health Screening questions above. I understand the benefits and risks of the Seasonal Influenza Vaccination and ask that the vaccine be administered.

Signature of Parent/Legal Guardian: _____

Date: _____

FOR STAFF USE ONLY:

Temp of Child: _____

Temp of Person Accompanying Child _____