

Intranasal Influenza (FluMist) Vaccine Questionnaire

Please answer the following questions about your child.

Child's Name

Date of Birth

1. Is your child 2 years or older? No Yes
2. Does your child have an allergy to chicken eggs or egg products? Yes No
3. Has your child ever had an allergic reaction to the influenza or H1N1 vaccine? Yes No
4. Does your child have a known or suspected disease or condition that weakens your immune system such as HIV infection, cancer, leukemia, lymphoma, agammaglobulinemia, or problems with your thymus? Yes No
5. Does your child live with someone who has a weakened immune system due to the reasons listed above? Yes No
6. Does your child presently taking medication or treatments that may weaken your immune system such as radiation, methotrexate, chemotherapy or other cancer treatment? Yes No
7. Does your child or adolescent regularly take aspirin or aspirin containing products? Yes No
8. Does your child have a history of Guillain-Barré Syndrome? Yes No
9. Does your child have a history of asthma, recurrent wheezing, reactive airway disease, or have a history of using Proventil or Albuterol? Yes No
10. Does your child have any underlying medical condition such as (but not limited to) chronic disorders of the lung and heart such as congestive heart failure or cardiomyopathy? Yes No
11. Does your child see a healthcare provider regularly because of a chronic illness such as diabetes, kidney problems, Hemoglobinopathy, or sickle cell disease? Yes No
12. Is your child/adolescent pregnant or nursing? Yes No
13. Has your child had an illness with symptoms of severe nasal congestion, sinus drainage, or fever within the last 3 days? Yes No
14. Has your child received any vaccine within the last 30 days? Yes No
15. My child is under 9 years old.
I understand that if my *child is under 9 years old AND getting the influenza vaccine for the very first time in his/her life*, he/she should get 2 doses of the vaccine. I will schedule an appointment for the second dose 1 month later. Yes No
16. I'm not sure of my child's previous influenza/H1N1 vaccine record and would like the medical staff to check if I need to return for a second dose this season. Yes No
check & let me know
17. I have read and understand the information on the vaccine information statement provided and would like my child to receive the intranasal influenza vaccine. No Yes

Signature of or Parent/Guardian

Date

Reviewed by _____, M.A, R.N, M.D