

# Flu Shot Visit 2020/2021 Parent/Guardian

**Adults Name:**

**DATE OF BIRTH:**

**Age:**

**Does the above listed person have...?**

- Yes  No A serious allergy to eggs or egg products?
- Yes  No A fever over 101°?
- Yes  No A past severe reaction to the flu shot?
- Yes  No A history of Guillain Barre Syndrome?
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- Yes  No Taking an aspirin regimen prescribed by a doctor?
- Yes  No Taking an medication prescribed by a doctor List: \_\_\_\_\_
- Yes  No Contact with a transplant patient?
- Yes  No Asthma requiring medicine in last year?
- Yes  No Chronic Illness such as: heart disease, diabetes, kidney disease, immune system, or hemoglobin disorder,  
Other: \_\_\_\_\_?
- Yes  No Are you pregnant or breastfeeding?
- Yes  No Received the MMR or Chicken Pox vaccine in the last month?

I have read and I understand the information given to me, including the Vaccine Information Statement (VIS). I have had a chance to ask questions, which were answered to my satisfaction. I believe that I understand the benefits and risks of taking the flu vaccine, and I request that the vaccine be given to me or to the person named for whom I am authorized to sign. I also understand that Beittel-Becker Pediatric Associates will not bill my insurance and that this shot is being provided as a courtesy to me. No receipt of vaccination will be given.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

FOR OFFICE USE:

Flulaval QIV PF  
0.5 ml (90686)

Flumist QIV PF  
(90672)

**Administered By:** \_\_\_\_\_

**Administered:**  LA  RA  Intranasal **Lot #:** \_\_\_\_\_ **Exp:** \_\_\_\_\_

**\$35 Fee collected by:** \_\_\_\_\_