BEITTEL-BECKER PEDIATRIC ASSOCIATES
2150 Noll Drive, Suite 100
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D Brosbe MD D Brown DO G Laube MD
B Martin PA-C A Funk Sweigart CRNP

Flu Shot Visit

Patient Name: _____ **DATE OF BIRTH:** _____ **AGE:** _____

Insurance Company: **Ins. ID (required if new):**

Does the above listed Patient 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?

☐ Yes ☐ No Taking aspirin regimen prescribed by a doctor?

☐ 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 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.

Signature:_____ **Date**:_____

FOR OFFICE USE:

☐ **Flulaval QIV PF** **0.5 ml (90686)**

☐ **Flumist QIV PF** **(90672)**

Administered By: _____

Administered: ☐ **LA** ☐ **RA** ☐ **LT** ☐ **RT** ☐ **Intranasal** **Lot #:**_____ **Exp:** _____

VFC Given: ☐ **YES** ☐ **NO**

Updated 6/15/2020dk