Lynn Keefe, MD
pediatrics

Flu Vaccine Screening Checklist

PLEASE FILL OUT ALL INFORMATION EVEN IF CURRENT PATIENT

Name (Last, First, Middle) _____

Address _____City _____Zip_____

Age _____ DOB _____ Insurance Co._____

Policy#_____

Are you pregnant?	YES	NO
Are you sick today?	YES	NO
Do you have a cochlear implant?	YES	NO
Have you ever had a serious reaction after receiving any vaccines?	YES	NO
Have you received the MMR, VZV, or any LIVE vaccines in the past 4 WEEKS?	YES	NO
Do you have any long-term health problems (Heart Disease, Asthma, Kidney Disease, Blood Disorders)?	YES	NO
Do you have any Immune System Problems (HIV/Leukemia/Cancer/Etc.)?	YES	NO
Are you on any medicines that weaken your immune system or have you taken any within the last 3 MONTHS (steroids, prednisone, cortisone, radiation treatments, anticancer medicine)?	YES	NO
During the past YEAR have you had a Blood Transfusion or Blood Products or been given Immune Gamma Globulin?	YES	NO

Please read and sign the following:

I have had the opportunity to read the Vaccine Information Sheet and ask for a personal copy if I desire. I consent to the administration of the Flu Vaccine; I understand that my insurance will be billed and that I am responsible for any charges that are not covered by my insurance.

Patient/ Parent Signature _____

Date _____

Phone Number _____

For Office Use Only:

Vaccine Given: Flu IM or Flu Mist
Lot #: Site: Administered by: Billed: