University Hospitals
Rainbow Babies & Children's

Flu Vaccine Clinic Questionnaire

Patient Name: _____

DOB___/___/___ Age: ____

Your child will not receive the flu vaccine today if they are not a patient here at Partners in Pediatrics

COVID-19 SCREENED OK Employee initials _____

1. YES NO Has your child been seen in this office by one of our physicians?

2. YES NO Child is a patient of our practice.

3. YES NO Does your child have any allergies?

4. YES NO Has child had a fever within past 24 hours or illness at present? If yes, CANNOT RECEIVE TODAY.

If Child is 6 months to 8 years old please answer following question.

5. YES NO NOT SURE Has your child received a total of 2 or more doses of Influenza vaccine in the past?*

*** Unless Yes to question 5 child receives 2 doses.**

Doses should be administered a minimum of 4 weeks apart.

If child is 9 years or older administer 1 dose.

Parent Consent: _____Date:___/____/_____

Office Use Only

Site	Lot #	Exp date	Manufacturer	MA signature
___	_____	___/___/___	_____	_____

REVISED: Sept 2022