Pediatric Health Associates, P.C.

FLU VACCINE HISTORY - Injectable

FOR NON-PHYSICIAN VISIT

Parents Must Complete the Following:

Name ______________________________ Date ________________

Street Address _____________________________________, City _____________________, Zip __________

DOB __________/_____/______ Age _____ Phone # _____________________________________

Allergies: ___________________________ Current Medications: ____________________________________

Diagnosis Code = Z23

1. Is the person to be vaccinated sick today? YES NO
2. Does the person to be vaccinated have an allergy to a component of the vaccine? YES NO
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? YES NO
4. Has the person to be vaccinated ever had Guillain-Barre syndrome? YES NO

If you have answered "yes" to any of the above questions the clinical staff member must consult with a physician and obtain a specific written order before the vaccine can be administered:

Comments: ____________________________________ ______________

______________________________ ____________________

Signature Date

90686 - Flu Shot: Sanofi Pastuer Product **Lot#**_______________ **Exp.**___________

90686 - (VFC) Flu Shot: Product **Lot#**_______________ **Exp.**___________

Date Administered:_________________________ By: _____________________________

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