

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. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | YES | NO |
| 3. Has the person to be vaccinated ever had Guillain-Barre syndrome? | YES | NO |

If you have answered "yes" to questions 1-3, the clinical staff member must consult with a physician and obtain a specific written order before the vaccine can be administered:

Comments: _____

Signature Date

90661- Flu Shot: Seqirus Flucelvax Lot# _____ Exp. _____

90656- (VFC) Flu Shot: _____ Product Lot# _____ Exp. _____

Date Administered: _____ By: _____