Pediatric Associates of Wylie P.A.

Patient's Name: _____

Date of Birth: _____Age: _____

Screening Questionnaire for Influenza Vaccination

Please circle one answer to the following questions.

Did the person to be vaccinated have seasonal influenza vaccine in 2020 flu season?	Yes	No	Don't Know
Has the person to be vaccinated:			
• had fever in the last 24-48 hours?	Yes	No	
• been tested or suspected of having COVID-19 in the last 14 days?	Yes	No	
• been exposed to anyone who has been infected with or suspected to have COVID-19 in the last 14 days?	Yes	No	
• Have cough, nasal congestion, runny nose, sore throat, loss of taste or smell, vomiting or diarrhea?	Yes	No	
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	Yes	No	Don't Know
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past (including Guillain Barre)?	Yes	No	Don't Know
Is the person to be vaccinated over 2 years old?	Yes	No	
Is the person to be vaccinated over 50 years old?	Yes	No	
Does the person to be vaccinated have any history of wheezing/asthma?	Yes	No	
If yes, approximately how long ago was the last episode of wheezing? _____			
Is the person to be vaccinated currently taking aspirin daily?	Yes	No	Don't Know
Has the person to vaccinated taken Tamiflu in the past 48 hrs., Xofluza in the last 3 weeks or any antiviral medication?	Yes	No	Don't Know
Has the person to be vaccinated received any live vaccines in the last 4 weeks? (MMR/Chickenpox)	Yes	No	Don't Know
Does the person to be vaccinated have a chronic disease or cochlear implants?	Yes	No	
Is the person to vaccinated in contact with someone whose immune system is suppressed? (HIV, cancer therapy)	Yes	No	
Would you like FluMist if available and appropriate?	Yes	No	
Is the person to be vaccinated pregnant?	Yes	No	Don't Know

Influenza Vaccination Policy

Our office will file with your insurance for the administration of the influenza vaccination. If your insurance deems this as a non-covered expense, then you will be billed $35 for standard Influenza vaccination and $45 for nasal Flu Mist vaccination.

Patient:_____
(Please Print Name)

Parent Signature:_____

Date:_____

FOR OFFICE USE ONLY

I have reviewed the above questionnaire:

Mist:

☐ 2 years – 49 years: PFQ FLUMIST 90672

Injection

☐ 6 months - Adult: PFQ FLULAVAL 90686

☐ 6 months - Adult: PFQ FLUARIX 90686,3+

Needs another flu vaccine in _____ weeks

Physician Signature:_____