

# Northpoint Pediatrics

## **Injectable Flu Vaccine Checklist**

Name \_\_\_\_\_

- |                                                                            |     |    |
|----------------------------------------------------------------------------|-----|----|
| 1. Has your child ever had a serious reaction to the flu vaccine?          | Yes | No |
| 2. Has your child eaten eggs or egg products in the past?                  | Yes | No |
| 3. Has your child had an allergic reaction to egg or egg products?         | Yes | No |
| 4. Has your child been diagnosed with Guillain-Barre in the past?          | Yes | No |
| 5. Has your child ever been diagnosed with a chronic illness or condition? | Yes | No |

If so, what? \_\_\_\_\_

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FOLLOWING QUESTION TO BE COMPLETED ON DATE OF SERVICE:

Has your child had any fever (>101) or respiratory illness in the last 24 hours?	Yes	No
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