
NOTE: Masks continue to be required for entry to our care sites and must be worn inside facilities at all times. Please bring your masks and put them on before entering the front door of the building.

FluMist Checklist
(Egg Based Flu Vaccine)

Patient name: _____

Date of birth: _____ Age: _____

Name of adult bringing child: _____

Relationship to child: _____

1. Does your child have a history of allergy to egg or egg products? Yes No
2. Has your child had Guillain-Barre syndrome in the past? Yes No
3. Has your child received any live vaccines in the last month? Yes No
4. Has your child ever been diagnosed with wheezing or asthma? Yes No
5. Does your child have any known or suspected immune deficiency? Yes No
6. Does your child live with anyone severely immunocompromised? Yes No
7. Does your child have any chronic health condition such as heart disease, kidney disease, diabetes, blood disorder, HIV or AIDS? Yes No

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