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.

INJECTABLE FLU VACCINE CHECKLIST
(Egg Free Flu Vaccine)

Patient name: ____

Date of birth: ___________________________ Age: ________________

Name of adult bringing child:___________________________________

Relationship to child:____

1. Has your child received a flu vaccine in the past? Yes No
2. If yes, was last year their first time receiving the flu vaccine? Yes No
3. Did they receive 1 or 2 doses last season? 1 2
4. Has your child ever had a serious reaction to the flu vaccine? Yes No
5. Has your child had Guillain-Barre syndrome in the past? Yes No
6. Has your child had a COVID vaccine or going to have a COVID vaccine in the next 14 days? Yes No
7. Has your child ever been diagnosed with a chronic illness or condition? If so, what? _______________________________________ Yes No

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FOLLOWING QUESTION TO BE COMPLETED ON DATE OF SERVICE:

Has your child had any fever or illness in the past 24 hours? Yes No