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? _____

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