

Riverdale Pediatrics, P.C.

Child's name:

Date of birth:

Influenza Vaccine Screening Questionnaire

2020-2021 Influenza Season

Is the patient sick today?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
Does the patient to be vaccinated have an allergy to a component of the vaccine?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
Has the patient to be vaccinated today ever had a serious reaction to the influenza vaccine in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>

I have been given the information sheet regarding the flu vaccine (VIS date 08/15/2019) and understand the benefits and risks of this vaccine.

Your name

Your relationship to the child

Signature

Date

Office only. Form reviewed by: