Flu Questionnaire for Children

Yes  No  Don’t know

1. Is the child sick today?  ☐  ☐  ☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?  ☐  ☐  ☐
3. Has the child had a serious reaction to a vaccine in the past?  ☐  ☐  ☐
4. Has the child had a health problem with lungs, heart, kidney disease, metabolic disease (such as diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?  ☐  ☐  ☐
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?  ☐  ☐  ☐
6. If your child is a baby, have you ever been told that your child has had intussusception?  ☐  ☐  ☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?  ☐  ☐  ☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?  ☐  ☐  ☐
9. In the past three months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids or anticancer drugs, or had radiation treatments?  ☐  ☐  ☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?  ☐  ☐  ☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?  ☐  ☐  ☐
12. Has the child received vaccinations in the past 4 weeks?  ☐  ☐  ☐

Consent:
Parent Signature___________________________________________ Date____________
Parent Name Printed_____________________________________________

Nursing Use Only:

<table>
<thead>
<tr>
<th>Vaccine Name</th>
<th>Date Administered</th>
<th>Lot Number</th>
<th>Exp. Date</th>
<th>Manufacturer</th>
<th>Site Administered</th>
<th>Administered By</th>
</tr>
</thead>
</table>

Insurance Information:
Insurance Type: MaineCare  Anthem  Cigna  Community Health Options  Medicare  Harvard Pilgrim  United Healthcare  Aetna
Other: ___________________________  Primary Care Provider: ___________________________
Policy Number: ___________________  Group Number: __________________________

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