Parent Flu Form

Parent Name:_____ **Parent DOB**:_____

Phone: _____

Do you have the same insurance as your child? Yes No

Full name of child at the practice_____

I understand that if my insurance is different from that of my child, I am responsible for paying for my flu vaccine at the time of service.

Tosa Pediatrics Influenza Vaccine Screening Questionnaire

For vaccine recipients: Please answer the following questions. If the questions are unclear, please ask your healthcare provider.

1.	Have you had a fever in the last 24 hours?	Yes	No	Don't Know
2.	Do you have any allergies to medications, foods, chemicals, latex, or any vaccines? If yes, please describe. _____.	Yes	No	Don't Know
3.	Have you had a serious reaction to the flu vaccine in the past? If yes, please describe: _____.	Yes	No	Don't Know
4.	Have you had a neurological illness, such as Guillain-Barre' syndrome (a progressive paralysis of the body)?	Yes	No	Don't Know

Flu Mist Only Questions

5.	Has a healthcare provider told you that you have had wheezing or asthma in the last 12 months?	Yes	No	Don't Know
6.	Do you plan on having close contact within the next 7 days with any individuals who's immune system is severely compromised?	Yes	No	Don't Know
7.	Have you received a vaccine in the last 4 weeks?	Yes	No	Don't Know
8.	Are you over the age of 49?	Yes	No	Don't Know

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statement for the vaccine (www.OCPH.info). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the Flu vaccine be given to the person named above for whom I am authorized to make this request. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. A copy of this consent form is as valid as the original.

Signature: _____ Date: _____

For office use only:

Type/Lot:_____ Location:_____ Administered by:_____

DOS: _____ Provider

TR	TM	NK	KK	JG	MN

Vaccine: ☐ Flucelvax 90674 ☐ FluMist 90672