WESTSIDE PEDIATRICS

FLU VACCINE/COVID-19 SCREENING QUESTIONNAIRE

Parent/Guardian Name: _____

Contact #: _____

Child's Name: _____ DOB: _____

Allergy to eggs or component the flu vaccine? ☐ NO ☐ YES

Serious reaction to the flu vaccine in the past? ☐ NO ☐ YES

In the past two weeks, any known exposure to Covid-19? ☐ NO ☐ YES

In the past 24 hours has the patient had any fever, cough, sore throat, diarrhea, shortness of breath or loss of taste/smell? ☐ NO ☐ YES

Please complete the section below if your child is under 18 and will be coming without a parent or guardian:

I consent to the administration of the following vaccine(s) to be given to my child:

☐ Influenza vaccine

☐ Other vaccine(s): _____

The **Vaccine Information Statement** (VIS) for the above vaccine(s) has been made available to me and may be reviewed at www.cdc.gov/vaccines/hcp/vis/

I have read the contraindications and have discussed any concerns with my healthcare provider and I give permission and written consent to Westside Pediatrics PC to administer the above vaccine(s).

Parent/guardian signature _____

Patient signature (18 years and older only) _____

(for official use only)

☐ L Deltoid
☐ R Deltoid
☐ L thigh
☐ R thigh