



# SOUTHERN ORANGE COUNTY PEDIATRIC ASSOCIATES

"Great Care for Great Kids"

## FLUMIST VACCINE SCREENING

Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Temp \_\_\_\_\_ Account # \_\_\_\_\_

**Please check answers as they apply to your child:**

	<b>Yes</b>	<b>No</b>
Serious allergic reaction to eggs, Thimerosal, gelatin, Arginine or Gentamycin?	<input type="checkbox"/>	<input type="checkbox"/>
History of Guillain-Barre syndrome or allergic reaction to previous flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Feeling sick today with a fever of >100° F or cold symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child taken an anti-viral medication within the last 48 hrs?	<input type="checkbox"/>	<input type="checkbox"/>
Has a healthcare provider ever told you that your child has asthma or wheezes?	<input type="checkbox"/>	<input type="checkbox"/>
Have diabetes, heart disease, kidney disease or are immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
Received another live vaccine (MMR, Chickenpox) in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Lives with or visits someone who is severely immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
On chronic aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Received Flumist in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
Female only: Currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_