



**Influenza Vaccine Parent Questionnaire**

Your child is scheduled to receive the flu vaccine. Please circle the answer to each of the following questions about your child.

Name of Child \_\_\_\_\_

Date of Birth \_\_\_\_\_

Is your child allergic to eggs? Yes or No

Is this the first time your child will receive the flu vaccine? Yes or No

Does your child have a fever today? Yes or No

Does your child have a cold today? Yes or No

Does your child have a seizure disorder? Yes or No

If you answered yes to any of these questions, a physician or nurse practitioner must see your child before a decision is made whether your child should receive the vaccine today.

I, \_\_\_\_\_ hereby give permission to South River Pediatrics to administer flu vaccine to my son/daughter \_\_\_\_\_. I also understand that South River Pediatrics will not submit to my insurance company for the cost of the vaccine.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician signature: \_\_\_\_\_