TRESTLEWOOD PEDIATRICS
SCREENING QUESTIONAIRE
FOR INACTIVATED **INJECTABLE** INFLUENZA VACCINATION

First Name: ___________________________________ Age: _____________

Last Name: ___________________________________ Date of Birth: _____________

PLEASE CIRCLE YES OR NO:

1. Is your primary insurance a Medicaid plan? YES NO

2. Is the person to be vaccinated sick today? YES NO

3. Is the person to be vaccinated severely allergic to eggs or any component of the flu vaccine? YES NO

4. Has the person to be vaccinated received flu vaccination before? YES NO

5. Has the person to be vaccinated ever had a serious reaction to flu vaccine or Guillain-Barre Syndrome? YES NO

   If yes, please describe: _____________________________________ __________________

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**I hereby authorize my insurance benefits to be paid directly to Trestlewood Pediatrics, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to the insurance carrier(s).

Parent/Guardian Signature: ____ Date: ____________
(or Patient if > 18 years of age)

****** FOR CLINICAL USE ONLY ******

Vaccine Type: 90686
> 3 IIV4
CVX 150

Date Vaccinated: __________________

Manufacturer and Lot Number: __________________

Injection Site: RL RA LL LA Dose: 0.5 ml

Immunizer Initials: ________

**We advise yearly well child visits. Please schedule an appointment if your child is due.