TRESTLEWOOD PEDIATRICS

Robert B. Page, M.D., F.A.A.P.
Stephanie Somers, M.D., F.A.A.P.
Anthony J. Van Es, M.D., F.A.A.P.
Rebekah Lampart, M.D., F.A.A.P.

Screening Questionnaire for Inactivated Injectable Influenza Vaccination

First Name: _____ Age: _____

Last Name: _____ Date of Birth: _____

Please indicate 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 have Guillain-Barre Syndrome? ☐ Yes ☐ No

   If yes, please describe: _____

   _____

**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/Lot No: _____/_____
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.
Please print a copy of this form and bring it with you to your flu vaccination.

5082 Lovers Lane • Portage, MI 49002 • Phone: 269-381-0118 • Fax: 269-381-4610 • www.trestlewoodpediatrics.com