Primary Care Pediatrics, PC
763 Peachtree Pkwy, Suite 2
Cumming, GA 30041
Ph#:678-208-2050
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DATE:_____ ***Are you 49 years or older YES_____***
NO_____

NAME:_____

DOB:_____

The American Academy of Pediatrics recommends flu vaccine for the following children:

1. ***All children between the ages of 6 months and 23 months***
2. ***Children over 23 months with chronic medical conditions – but no limited to asthma or wheezing, respiratory conditions diabetes, heart problems, liver and kidney problems***
3. ***Older healthy children up to 18 years***

****If your child was 8 years of age and younger and received flu vaccine for the first time last year, they will only need 1 dose this year. A signed consent in the form of a questionnaire must be completed on behalf of your child in order to receive these vaccines.***

1. ***Are you allergic to eggs, gentamicin, gelatin, or arginine?*** ***Y/N***
2. ***Do you have any problem with your immune system?*** ***Y/N***
3. ***Do you have AIDS, HIV, cancer or have you received an organ transplant?*** ***Y/N***
4. ***Did a doctor ever tell you that you had asthma or reactive airway disease?*** ***Y/N***
5. ***Do you have any disease of the lungs such as cystic fibrosis?*** ***Y/N***
6. ***Did you ever have Guillain-Barre Syndrome or active neurological disease?*** ***Y/N***
7. ***Do you have kidney disease?*** ***Y/N***
8. ***Are you pregnant or nursing?*** ***Y/N***
9. ***Do you have heart disease?*** ***Y/N***
10. ***Do you have a blood disease like sickle cell disease or thalassemia?*** ***Y/N***
11. ***Do you currently have a cold or other respiratory illness?*** ***Y/N***
12. ***Do you have a fever?*** ***Y/N***
13. ***Have you received or plan to receive any vaccines in the next month?*** ***Y/N***
14. ***Are you taking any prescription medicines to prevent or treat the flu?*** ***Y/N***
15. ***Does anyone living with you have a compromised immune system?*** ***Y/N***
16. ***Do you have diabetes or other metabolic disease?*** ***Y/N***
17. ***Are you taking any medications currently?*** ***Y/N***

Parent Signature:_____

Vacc	Date	Age	Site	Mfg	Lot#	Exp	VIS	DOS	nurse	parent