BEST ANGELS PEDIATRICS
7950 Cherry Ave. STE 105. Fontana, CA 92336. Phone: (909) 434-1657 Fax: (909) 231-6231

Flu Vaccine Form

Patient Name: _____ Date: _____ F: ☐ M: ☐

DOB: _____ Age: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS). I understand the risks and benefits associated with the influenza vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request.

_____ _____

Signature Date

Screening Questionnaire						
Are you currently ill or do you have a fever?	☐	Yes	☐	No	Unknown	☐
Have you received the vaccine before?	☐	Yes	☐	No	Unknown	☐
Have you had a reaction to the vaccine before?	☐	Yes	☐	No	Unknown	☐
Have you been sick in the last 2 weeks?	☐	Yes	☐	No	Unknown	☐
Are you allergic to egg or dairy products?	☐	Yes	☐	No	Unknown	☐
Are you allergic to thimerosal?	☐	Yes	☐	No	Unknown	☐
Are you pregnant?	☐	Yes	☐	No	Unknown	☐
Are you a Health Care worker?	☐	Yes	☐	No	Unknown	☐
Have you ever had Guillain-Barre syndrome?	☐	Yes	☐	No	Unknown	☐
Do you have a blood-clotting disorder?	☐	Yes	☐	No	Unknown	☐
Are you taking blood-thinning medication?	☐	Yes	☐	No	Unknown	☐

For Office Use Only

Date Given: _____ Manufacturer & Lot #: _____

Exp. Date: _____ Site: RT ☐ LT ☐ RD ☐ LD ☐

Route: _____ Administered By: _____