Date: _____ Date of birth: _____

Patient name: _____ _____
Last First

Does your child have asthma? _____
Has your child wheezed or needed a breathing treatment or inhaler in the last year? _____
Has your child had any adverse reaction to vaccines? _____
Does your child have any immune deficiencies or other health problems? _____
Has your child had a flu mist, MMR or chicken pox vaccine in the last 30 days? _____
Is your child currently ill or has had a fever in the past 48 hours? _____
Has your child had Guillain – Barre syndrome? _____
Is there a possibility your child could be pregnant? _____

"I have read or have had explained to me information about the indicated vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the indicated vaccine be given to me or the named person for whom I am authorized to make the request."

Sticker here

Site given:
Intranasal

Signature of vaccine admin: _____

Signature of parents: _____

## Seasonal Influenza Vaccine 2025-2026 - Flumist