**Lake Pointe Pediatric Associates, P. A.**

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**INFLUENZA VACCINATION QUESTIONS**

Patient Name: DOB:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PLEASE CHECK THE APPROPRIATE BOX TO**  **INDICATE YOUR RESPONSE TO EACH QUESTION.** | | | | **YES** | | **NO** |
|  | | | |  | |  |
| Do you currently have moderate or severe illness with or without fever? | | | |  | |  |
| Have you ever had any serious reaction to eggs, egg proteins, gelatin, or arginine? | | | |  | |  |
| Have you ever had any serious reaction to neomycin, polymyxin, or gentamicin? | | | |  | |  |
| Have you ever had any serious reaction after receiving a dose of influenza vaccine? | | | |  | |  |
| Do you have a history of Guillain-Barre syndrome? | | | |  | |  |
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|  | | | |  | |  |
|  |  |  |  | |  | |
| Parent/Guardian Name (PRINT) Parent/Guardian Signature Date | | | | | | |

*This form must be completed and given to the nurse*

*before an influenza vaccination can be administered.*