FLU IMMUNIZATION QUESTIONNAIRE

Childs Name: _____

Childs DOB: _____

1. Is your child allergic to eggs? □ YES □ NO
   a. If yes, please describe the reaction_____
      _____
2. Is your child allergic to latex products? □ YES □ NO
   a. If yes, please describe the reaction_____
      _____
3. Does your child have a history of Asthma? □ YES □ NO

Please check with your clinical staff person or physician if you have any questions regarding this questionnaire.

Parent/Guardian Signature_____Date:_____

FOR OFFICE STAFF ONLY

Temp_____

Manufacturer_____Lot #_____Expiration_____

Route_____Site_____Initials_____