MARGARET MARY HEALTH

Health Screening for Flu Vaccine

| Child's Legal Last Name: | Child's Legal First Name: | Age: | Date of Birth: |
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There are 2 forms of influenza vaccine available: the FluMist (nasal spray) and the Flu Shot (injection)

**If you answer "YES" to questions 1-3, your child CANNOT receive any form of the flu vaccine. If you answered "YES" to any questions 4-12, your child cannot receive the FluMist nasal spray, but can still receive the flu shot (injection). If you have any questions or concerns, contact your child's physician.**

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| 1. Has your child ever had a severe (life-threatening) allergic reaction to a previous influenza vaccine? Allergic reaction: hives, rash that covers body, difficulty breathing, etc. | ❒ This is the first time he/she has ever received an influenza vaccine | **Yes No** |
| 2. Does your child have a severe (life-threatening) allergy to eggs? | | **Yes No** |
| 3. Has your child ever had Guillain-Barre syndrome? (A rare nerve disorder that can cause paralysis) | | **Yes No** |
| 4. Does your child have a severe (life-threatening) allergy to gentamicin, gelatin, or arginine? | | **Yes No** |
| 5. Is your child currently receiving aspirin or aspirin-containing (salicylate) treatment? | | **Yes No** |
| 6. Does your child have asthma, reactive airway disease, recurrent wheezing, or active wheezing? | | **Yes No** |
| 7. Does your child have a muscle or nerve disorder (such as seizures or cerebral palsy) that can lead to breathing or swallowing problems? | | **Yes No** |
| 8. Does your child have any diseases (for example cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids and chemotherapy) that lowers the body's resistance to infection? | | **Yes No** |
| 9. Is your child pregnant or nursing? | | **Yes No** |
| 10. Does your child have close contact with anyone who has a weakened immune system (an individual who has had a bone morrow transplant and currently hospitalized in isolation)? | | **Yes No** |
| 11. Has your child received the MMR (mumps, measles, rubella) or the Chicken Pox (varicella) vaccine in the last 30 days? | | **Yes No** |
| 12 Does your child have any long-term health problem(s)? For example: Heart, Lung, Kidney, Liver and/or metabolic (i.e. diabetes) disease | | **Yes No** |

**13. I would like my child to receive:** ❒ **FluMist Nasal Spray** ❒ **Flu Shot (injection)**

**14. Signature: _____Date:_____**

**(Parent or Guardian's Signature required if child is 17 years or younger)**