Virginia Pediatric Group — Fairfax

Date: ___/___/____

Screening Questionnaire for Intranasal Influenza Vaccination

Patient Name:_____ **Age**_____ **Date Of Birth:**_____

1. Is the person to be vaccinated sick today? **YES** ☐ **NO** ☐

2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine? **YES** ☐ **NO** ☐

3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past? **YES** ☐ **NO** ☐

4. Is the person to be vaccinated younger than age 2 years or older than age 49 years? **YES** ☐ **NO** ☐

5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders? **YES** ☐ **NO** ☐

6. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs? **YES** ☐ **NO** ☐

7. Is the person to be vaccinated between the ages of 5 and 17 years **and** receiving aspirin therapy or aspirin-containing therapy? **YES** ☐ **NO** ☐

8. Is the person to be vaccinated pregnant or could she become pregnant within the next month? **YES** ☐ **NO** ☐

9. Has the person to be vaccinated ever had Guillain-Barré syndrome? **YES** ☐ **NO** ☐

10. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)? **YES** ☐ **NO** ☐

11. Has the person to be vaccinated taking any Tamiflu, Relenza, amantadine, or rimantadine **YES** ☐ **NO** ☐

If you answered yes to any of the above, your physician will have to determine if FluMist is right for you.

I have read the above information about FluMist and have truthfully answered all of the questions on this form. I have also received a copy of the Vaccine Information Statement for FluMist. I have had a chance to ask questions and fully understand the benefits and risks of vaccination with FluMist. My signature below indicates my permission for FluMist to be given to me. I further understand that insurance coverage for these vaccines vary depending on the plan and/or medical necessity. Therefore, upon rejection of this service from my insurance, I agree to remit payment in full to Virginia Pediatric Group. If I choose to submit this fee to my insurance company Virginia Pediatrics will not reimburse the difference between insurance and the fee.

Flu Vaccine: PARENTAL VACCINATIONS: I also understand that insurance will not be billed for the administration of my flu vaccine, and I will pay $45 for this vaccine _____INITIALS

_____

Signature of Responsible Person Date:

Total Paid$_____ Cash_____ _ Check #_____Credit Card_____

_____ ProcedureCodes:90460,90473and90672

Signature of the Provider ICD10: Z23

Vaccine Manufacturer: _____ Lot No: _____

Site Given: _____ Initials of Vaccine Administrator:_____

Virginia Pediatric Group — Herndon

Date: ___/___/____

Screening Questionnaire for Intranasal Influenza Vaccination

Patient Name:_____ **Age**_____ **Date Of Birth:**_____

1. Is the person to be vaccinated sick today? **YES** ☐ **NO** ☐

2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine? **YES** ☐ **NO** ☐

3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past? **YES** ☐ **NO** ☐

4. Is the person to be vaccinated younger than age 2 years or older than age 49 years? **YES** ☐ **NO** ☐

5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders? **YES** ☐ **NO** ☐

6. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs? **YES** ☐ **NO** ☐

7. Is the person to be vaccinated between the ages of 5 and 17 years **and** receiving aspirin therapy or aspirin-containing therapy? **YES** ☐ **NO** ☐

8. Is the person to be vaccinated pregnant or could she become pregnant within the next month? **YES** ☐ **NO** ☐

9. Has the person to be vaccinated ever had Guillain-Barré syndrome? **YES** ☐ **NO** ☐

10. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)? **YES** ☐ **NO** ☐

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Signature of the Provider ICD10: Z23

Vaccine Manufacturer: _____ Lot No: _____

Site Given: _____ Initials of Vaccine Administrator:_____

Virginia Pediatric Group — Great Falls

Date: ___/___/____

Screening Questionnaire for Intranasal Influenza Vaccination

Patient Name:_____ **Age**_____ **Date Of Birth:**_____

1. Is the person to be vaccinated sick today? **YES** ☐ **NO** ☐

2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine? **YES** ☐ **NO** ☐

3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past? **YES** ☐ **NO** ☐

4. Is the person to be vaccinated younger than age 2 years or older than age 49 years? **YES** ☐ **NO** ☐

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Vaccine Manufacturer: _____ Lot No: _____

Site Given: _____ Initials of Vaccine Administrator:_____

Virginia Pediatric Group — Aldie

Date: ___/___/____

Screening Questionnaire for Intranasal Influenza Vaccination

Patient Name:_____ **Age**_____ **Date Of Birth:**_____

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