Patient Name:_____________________________________ Date of birth:_____/______/______

Screening Questionnaire for Live Attenuated Intranasal Influenza Vaccine (FluMist)

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1.) Is the person to be vaccinated sick today?	☐	☐	☐
2.) Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
3.) Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine(FluMist) in the past?	☐	☐	☐
4.) Is the person to be vaccinated younger than 2 years or older than 49 years?	☐	☐	☐
5.) Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
6.) If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	☐	☐	☐
7.) Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?	☐	☐	☐
8.) Is the person to be vaccinated receiving antiviral medications?	☐	☐	☐
9.) Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
10.) Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
11.) Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐
12.) 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 protective isolation?	☐	☐	☐
13.) Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

By signing this form, I acknowledge that I have been made aware of the benefits and risks associated with receiving the Inactivated Influenza vaccination. In addition, I acknowledge that I have read and/or received a copy of the vaccine information statements (VIS).

____ __________

Signature of patient/parent Date

____

Patient/ Parent Name (please print)

FOR OFFICE USE ONLY

Vaccine:________________ Date on VIS:_________

Date given:__________ Date VIS given:_________

Site:_______

Vaccine Lot#:__________________ ________________________________

Vaccinator's signature or initials

Healthy Pediatrics at Old Bridge, LLC
3 Athens Avenue
South Amboy, NJ 08879

Last Name: _____________________ First Name: _____________________ Date Of Birth: ____/____/____

Address:___________________________________ City: ____________ State: ____________ Zip: __________

Home Phone#: (___)_____________ Cell#: (___)____________ Work#: (____) ______________

MEDICAL INSURANCE INFORMATION

Are you covered by insurance?

☐ Yes ☐ No

Primary Insurance:____________________________ Subscriber's Name:__________________________

Subscriber's Date of Birth:____/_____/______ Relationship to Subscriber: ☐Self ☐ Spouse ☐Other_______

Co-Pay: $________ Policy ID#:_____________________________ Group#:_____________________

Secondary Insurance: ______________________________Subscriber's Name:________________________

Subscriber's Date of Birth: _____/_____/_____ Relationship to Subscriber: ☐Self ☐Spouse ☐Other_________

Co-Pay:$________ Policy ID#:_____________________________Group#:__________________________

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance(s) named in the MEDICAL INSURANCE INFORMATION section of this document may not be confirmed at this time. I wish to receive medical services from Healthy Pediatrics at Old Bridge, LLC. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL INFORMATION

I hereby assign to Healthy Pediatrics at Old Bridge, LLC any insurance benefits available for health care services provided to me. If these benefits are not assigned to Healthy Pediatrics at Old Bridge, LLC, I agree to forward all health insurance payments that I receive for services rendered immediately to Healthy Pediatrics at Old Bridge, LLC.

I authorize Healthy Pediatrics at Old Bridge, LLC to release the minimum necessary medical or other information to persons employed or retained by or affiliated with Healthy Pediatrics at Old Bridge for purposes of my diagnosis and treatment that may be required in order to process insurance payment. I agree that these provisions will remain in effect until I provide written notice to Healthy Pediatrics at Old Bridge that this authorization has been changed or discontinued.

____ ______________

Signature of Patient Date