TEMP:______

Delaware Valley Pediatric Associates

PATIENT NAME: ______________________________ **DOB**____________

Insurance Carrier Name______________________________________

Is your child a new patient? [ ] YES [ ] NO

Has your child had the flushot or flumist before? [ ] YES [ ] NO

Has your child had any recent illness? [ ] YES [ ] NO
If so, what? ______________________________

Has your child had a fever in the last 48 hours? [ ] YES [ ] NO

Is your child currently taking any medication? [ ] YES [ ] NO
If so, what? ______________________________

Is your child pregnant? [ ] YE S [ ] NO

Has your child had any prior reaction to immunizations? [ ] YES [ ] NO
If so, what? ______________________________

Does your child have history of Guillain-Barre Syndrome? [ ] YES [ ] NO

Has your child ever had an anaphylactic reaction to eggs? [ ] YES [ ] NO

Has your child had a live viral vaccine (ie: flumist, MMR, chicken pox) in the 30 days? [ ] YES [ ] NO

Has your child ever had Asthma or wheezing? [ ] YES [ ] NO

Has your child ever used a nebulizer, inhaler or any other "Asthma" medications. [ ] YES [ ] NO
If so, what?______________________________

Please circle any of the following that your child is allergic to:

Gentamicin (antibiotic) Bakers Yeast

Neomycin (antibiotic) Gelatin (Jell-O)

Polymyxin (antibiotic) Latex

Streptomycin (antibiotic) MSG

Arginine (corrects low chloride or is found in supplements)

FOR OFFICE USE:
LOT#______________
EXP.______________
SITE______________
GIVEN BY:__________