Ocean State Pediatrics 2020 Flu-Vaccine Screening Form

In preparation for your child's flu-vaccine appointment, please complete the following screening questions and insurance information. Please complete and bring one per child. Thank you!

Child's Name: ____ DOB: ________________________

Flu Visit Screening Questions

YES **NO** Has your child had a fever of greater than 100.4 degrees F in the past 24 hours?

YES **NO** Does your child have a history of an egg allergy?

YES **NO** Has your child had an adverse reaction to a flu vaccine in the past?

If you have answered yes to any of these questions, please call the office before coming for your appointment.

COVID Screening Questions

YES **NO** Has your child had a cough, shortness of breath, difficulty breathing, new change in taste or smell, fever greater than 100.4 degrees F, chills (rigors), body aches (myalgia), headache, sore throat, nausea, vomiting, diarrhea, fatigue, congestion or runny nose in the past two weeks?

YES **NO** Has anyone else in the household had any of the above symptoms in the past 2 weeks?

YES **NO** Has your child been exposed to someone with COVID and is therefore quarantining due to exposure in the past 2 weeks?

YES **NO** Has your child traveled outside of the state to a state with a greater than 5% positivity rate for COVID in the past 2 weeks?

If you have answered yes to any of these questions, please call the office before your appointment.

Insurance Information

Please provide your child's insurance name and ID number:

INSURANCE NAME: ____

INSURANCE ID NUMBER: ____

OFFICE USE ONLY: Brand name:_________________________ Administration Date:_____________

Lot Number:__________________________ Expiration Date:_________________