Ocean State Pediatrics

2022-2023 Flu Vaccine Form

In preparation for your child's flu vaccine appointment, please complete the following screening questions and insurance information. Please complete one per child and bring it to your vaccine appointment. 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 positively to any of the 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 your child tested positive for COVID-19 within the past 10 days?

If you have answered positively to any of the questions, please call the office before coming for 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:** _____