White: OV Blue: Flu Clinic Green: Cash Yellow: Medicaid/Star/Chip Date:_____

Cedar Park Pediatric & Family Medicine

Flu Vaccine (Shot)

Patient:_____ **DOB:**_____ **Age:**_____

(circle yes or no to all that apply):

1. Known allergies to eggs, chicken or chicken feathers	Yes	No
2. History of Guillain-Barre Syndrome (GBS)	Yes	No
3. A severe reaction to any vaccine component	Yes	No
4. Current fever	Yes	No
5. Previous problems with flu vaccine	Yes	No
6. **Do you participate in the Medicaid, Chip or Star Program?**	**Yes**	**No**

7. **Did you receive the current Flu Vaccine Information Statement?** **Yes** **No**

Patient/Guardian signature: _____

If "yes" to questions 1-6 , clinical staff consult with provider.
If "no" to questions 1-6, the patient is authorized to receive the appropriate dose and number of recommended doses of the flu vaccine.

DOSING RECOMMENDATIONS:

6-35 months	0.25 cc IM (1-2 doses)*	**90685**
3-8 years	0.50 cc IM (1-2 doses)*	**90688**
9 years or older	0.50 cc IM (1 dose)	**90688**
65 years or older	0.50 cc IM (1 dose) - -NEW – HIGH DOSE	**90662**

*Patients under 9 years of age who have never received an influenza vaccine should receive the 2 dose regimen with 4 weeks between doses. Both doses are recommended for maximum protection. A single dose is considered sufficient for those patients under 9 years of age who have received at least 1 prior dose of influenza virus vaccine.

Vaccine supplied by __CPPFM __State

Manufacturer: Lot #: Expiration Date:

AMOUNT: 0.25 cc IM **90685** 0.50 cc IM **90688** 0.5 cc IM(HD) **90662** SITE: R L Deltoid Anterior Thigh

Nurse Signature:_____ Date:_____

VAR entry:_____ Date:_____

Provider Signature: _____ Date:_____

Billed Charges : _____ Date: _____

Aug. 2015

White: OV Blue: Flu Clinic Green: Cash Yellow: Medicaid/Star/Chip Date:_____

Cedar Park Pediatric & Family Medicine

Flu Mist (Nose Spray)

Patient: _____**DOB:** _____**Age:** _____

(circle yes or no to all that apply)

1. History of Guillain-Barre Syndrome (GBS)	yes	no
2. Current Fever (100.4 or greater)	yes	no
3. History of allergy, including anaphylaxis, to any of the components of LAIV or to eggs	yes	no
4. Less than 2 yrs old or greater than 49 yrs old	yes	no
5. Long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (i.e. diabetes), or anemia or other blood disorder	yes	no
6. Close contact with someone who is severely immunosuppressed (ie.. HIV, persons receiving chemotherapy or high dose steroids)	yes	no
7. Aspirin therapy or other salicylates for a child or teen	yes	no
8. Pregnancy	yes	no
9. Received MMR or Varicella vaccine in the last month	yes	no
10. If patient to be vaccinated is a child age 2-4 years, in the past 12 months, has a doctor told you that he/she had asthma or wheezing?	yes	no
11. Live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (i.e. bone marrow transplant unit)?	yes	no
12. Currently taking antiviral medications (i.e. Tamiflu)	yes	no
13. **Do you participate in the Medicaid, Chip or Star program?**	**yes**	**no**
14. **Did you receive the current Flu Vaccine Information Statement?**	**yes**	**no**

Patient/Guardian signature: _____

If "yes" questions 1-13 the clinical staff will consult with provider.
If "no" questions 1-13 , the patient is authorized to receive the appropriate dose and number of recommended doses of the Flu Mist.

*Patients under 9 years of age who have never received an influenza vaccine should receive the 2 dose regimen with 1 month between doses. Both doses are recommended for maximum protection. A single dose is considered sufficient for those patients under 9 years of age who have received at least 1 prior dose of influenza virus vaccine.

Vaccine supplied by __CPPFM __State

Manufacturer: Medimmune Lot #: Expiration Date:
AMOUNT: 0.2 cc Bilateral Nares
90672

Nurse Signature:_____ Date:_____

VAR entry:_____ Date:_____

Provider Signature: _____ Date:_____

Billed Charges: _____ Date: _____

Aug. 2015