**Westerville Pediatric Specialists, Inc.**
575 Westar Xing, Ste 101
Westerville OH 43082
614/508-2223
Fax: 614/508-2233

**Sunbury Mills Pediatrics**
700 West Cherry St, Ste B
Sunbury OH 43074
740/965-6369
Fax: 740/965-6371

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# 2020-2021 Influenza

Name: _____ Date of Birth: _____

My child has had a physical within one year from today's date. Westerville Pediatric Specialists, Inc. will bill my insurance for the Influenza Vaccine. If insurance does not cover the cost below or reimburses less than the fee, I agree to be responsible for the balance due.

Influenza Vaccine
($45 per dose, includes administration)

_____ _____
Parent/Legal Guardian Signature Date

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## Complete this section ONLY if planning on receiving the nasal flu vaccine

| | 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 a component of the influenza vaccine? | □ | □ | □ |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | □ | □ | □ |
| 4. Is the person to be vaccinated younger than age 2 years or older than age 49 years? | □ | □ | □ |
| 5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen? | □ | □ | □ |
| 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 affect the immune system (e.g. prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs) or have they had radiation treatments? | □ | □ | □ |
| 8. Is the person to be vaccinated receiving influenza antiviral medications? | □ | □ | □ |
| 9. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine? | □ | □ | □ |
| 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-Barré 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 (e.g., an isolation room of a bone marrow transplant unit)? | □ | □ | □ |
| 13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? | □ | □ | □ |

OFFICE USE ONLY

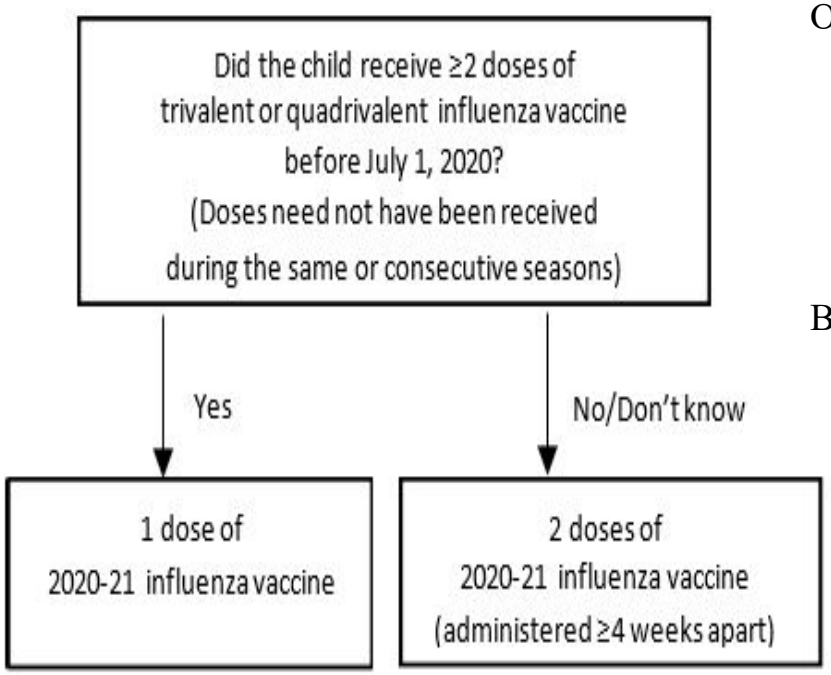
**How old is child?**

# PRIVATE

Is patient older than 9 years? YES → 0.5 _____ Mist (see other side) _____

or

NO ↓




One Dose: 0.25_____

0.5 _____

Mist (see other side) _____

Booster Scheduled: _____

0.25 _____

0.5 _____

Mist (see other side) _____

Form reviewed by _____ Date _____

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# 2020-2021 Influenza

Name: _____ Date: _____

My child has had a physical within one year from today's date. Westerville Pediatric Specialists, Inc. will bill my insurance for the Flu Mist or the Influenza Vaccine.

_____ _____
Parent/Legal Guardian Signature Date

---

## Complete this section ONLY if planning on receiving the nasal flu vaccine

| | 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 a component of the influenza vaccine? | □ | □ | □ |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | □ | □ | □ |
| 4. Is the person to be vaccinated younger than age 2 years or older than age 49 years? | □ | □ | □ |
| 5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen? | □ | □ | □ |
| 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 affect the immune system (e.g. prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs) or have they had radiation treatments? | □ | □ | □ |
| 8. Is the person to be vaccinated receiving influenza antiviral medications? | □ | □ | □ |
| 9. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine? | □ | □ | □ |
| 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-Barré 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 (e.g., an isolation room of a bone marrow transplant unit)? | □ | □ | □ |
| 13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? | □ | □ | □ |

OFFICE USE ONLY

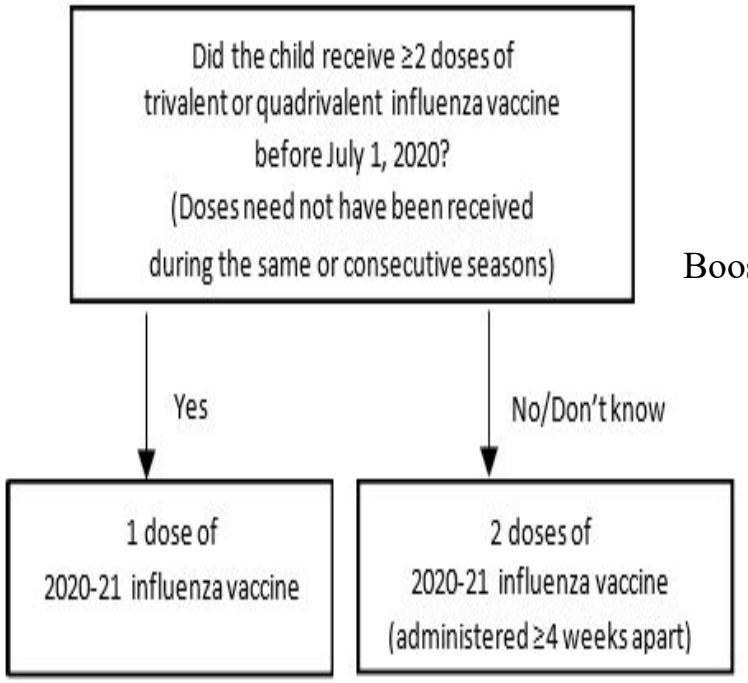
**How old is child?**

# VFC

Is patient older than 9 years? YES → 0.5 _____ Mist (see other side) _____

or

NO ↓




One Dose: 0.25_____

0.5 _____

Mist (see other side) _____

Booster Scheduled: _____

0.25 _____

0.5 _____

Mist (see other side) _____

Form reviewed by _____ Date _____