

**Cornerstone Pediatric & Adolescent Medicine**  
**97 Cornerstone Dr. Cary, NC 27519**  
**2011-2012 Flu Clinic**  
 (One information sheet per child)

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Has this child ever been seen by one of our Providers before?**  Yes  No

\*If not, please schedule a provider visit as we do not administer vaccine through our Flu clinic unless the patient is an established patient.

**Has the patient ever had the seasonal flu vaccine before?**  Yes  No

\*If not and less than 9 years old, it is recommended to get 2 doses of the flu vaccine this year at least 4 weeks apart.

**Has the patient had a fever within the last 24 hours?**  Yes  No

\*If yes, we recommend rescheduling the vaccine to a different date.

**Is the patient severely allergic to eggs?**  Yes  No

\*If yes, we do NOT recommend getting the flu vaccine.

**When they eat products that contain egg such as cakes/breads do they have a reaction?**

Yes  No \*If yes, we do NOT recommend getting the flu vaccine.

**Does the patient have a history of any of the following: (please circle all that apply)**

Asthma / Diabetes / Weakened Immune System

Other Chronic Illness (specify illness): \_\_\_\_\_

**I would like my child to receive today:**

Regular Flu Vaccine Injection

Flumist (nasal spray)-Not available for those younger than 2 years of age or those with certain medical conditions.

I have received a copy of the 2011-2012 Influenza Vaccine fact sheet. I understand the benefits and the risks of the vaccine and I am authorizing a qualified member of the Cornerstone Pediatric & Adolescent Medicine staff to administer the Influenza vaccine according to the guidelines set by the Centers for Disease Control and Prevention.

Parent or Legal Guardian Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 (If patient is under the age of 18 the signature of a parent or legal guardian must be obtained)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If 18 years of age or older)

**For Office Use Only**

Private Insurance  Medicaid  No Insurance

\*\*Always use state funded for /Medicaid/No Insurance\*\*

Injectable Vaccine < 36 Months Thimerosal Free 90655 <input type="checkbox"/>	Multi Dose < 36 months <u>Not</u> Preservative free 90657 <input type="checkbox"/>	Flu Mist 90660 <input type="checkbox"/>
Injectable Vaccine > 36 Months Thimerosal Free 90656 <input type="checkbox"/>	Multi Dose > 36 months <u>Not</u> Preservative free 90658 <input type="checkbox"/>	Private <input type="checkbox"/> State Funded <input type="checkbox"/>

**Administration Codes**

1 shot only - 90471 <input type="checkbox"/>	1 nasal only -- 90473 <input type="checkbox"/>
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Nurse Signature: \_\_\_\_\_ Manufacturer Lot #: \_\_\_\_\_ Exp: \_\_\_\_\_ Site: \_\_\_\_\_