

Name _____ Date of Birth _____

Screening Questions for Flu-Mist- for healthy 2-49 yr

Section 2: Information to determine if your child should get the nasal spray flu vaccine.

Please check YES or NO for each question.

If you answer "YES" to one or more of the questions below, your child will not be able to get the nasal spray vaccine in school unless there is a note from your child's health care provider saying it is ok for your child to get flu vaccine. If you answer "NO" to these questions, your child will receive the vaccine. If you are not sure of the answers, check with your child's healthcare provider.

| | NO | YES |
|--|----|-----|
| 1. Does your child have a problem eating eggs? | | |
| 2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin? | | |
| 3. Has your child ever had a serious reaction to a flu vaccine in the past? | | |
| 4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? | | |
| 5. Has your child received any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ____ day ____ year ____ | | |
| 6. Does your child have asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? | | |
| 7. If your child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months? | | |
| 8. Does your child take aspirin or aspirin-containing medicine every day? | | |
| 9. Does your child have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)? | | |
| 10. Is your child pregnant? | | |
| 11. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? | | |