The Children's Clinic of Wyomissing

Flu Mist Questionnaire

Patient's Name _____

D.O.B_____

Please check all that apply;

- Asthma or recurrent wheezing ☐
- Problems with heart, kidneys or lungs ☐
- Immunocompromised ☐
- Diabetes ☐
- Aspirin use ☐
- Egg anaphylaxis (severe allergic reaction) ☐
- MMR or Varicella vaccine in the past 4 weeks ☐

Guardian Signature_____ Date_____

8/26/2020