

Flu Vaccine Check-In Survey

1. Is your child sick today? Fever > 100.4, cough, congestion runny nose, sore throat, etc. Y/N
2. Does your child have asthma? Y/N
3. Does your child have an allergy to eggs? If yes describe reaction.
4. Has your child been exposed to COVID-19? Y/N
5. Has your child been exposed to anyone who is currently being tested for COVID-19? Y/N
6. Has your child been diagnosed with COVID-19?
7. Has your child been on anti-viral medication in the past week?
Y/N
Tamiflu, Xofluza, Oseltamivir