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Recommendations for Prevention and Control of Influenza in Children, 2026–2027: Policy Statement

Committee on Infectious Diseases

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AMERICAN ACADEMY OF PEDIATRICS

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

**Recommendations for Prevention and Control of Influenza in Children,
2026–2027: Policy Statement**

Committee on Infectious Diseases

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ABSTRACT. This statement updates recommendations of the American Academy of Pediatrics (AAP) for use of influenza vaccines and antiviral medications in prevention and treatment of influenza in children during the 2026–2027 influenza season. A review of evidence supporting these recommendations is in the accompanying technical report (<https://doi.org/10.1542/peds.2026-078779>).

The AAP recommends annual influenza vaccination of all children without medical contraindications starting at 6 months of age. Influenza vaccination is an important strategy for protecting children and the broader community as well as reducing the overall burden of respiratory illnesses when other viruses are cocirculating. Any licensed influenza vaccine

appropriate for age and health status can be administered, as soon as possible in the season, without preference for one product or formulation.

Antiviral treatment of influenza may reduce the duration of symptoms; reduce complications, including hospitalization and death; and potentially reduce transmission. The AAP recommends antiviral treatment for children with suspected or confirmed influenza who are hospitalized or have severe or progressive disease. In ambulatory settings, antiviral treatment should be offered to children who are at high risk of complications from influenza, including those with chronic medical conditions and immunocompromised patients. In all these situations, antiviral treatment should be started as soon as possible regardless of duration of illness or receipt of influenza vaccine. Antiviral treatment is an option in the ambulatory setting for all children with suspected or confirmed influenza.

Antiviral chemoprophylaxis is an option in certain individuals, especially exposed children who are asymptomatic and are at high risk for influenza complications but have not yet been immunized or, if immunized, those who are not expected to mount an effective immune response.

ABBREVIATIONS: AAP, American Academy of Pediatrics; FDA, US Food and Drug Administration; ccIIV, cell culture-based inactivated (non-live) influenza vaccine; ccIIV3, trivalent cell culture-based inactivated (non-live) influenza vaccine; HCT, hematopoietic cell transplant; IIV, inactivated (non-live) influenza vaccine; IIV3, trivalent inactivated (non-live) influenza vaccine; LAIV, live attenuated influenza vaccine; LAIV3, trivalent live attenuated influenza vaccine; RIV, recombinant influenza vaccine; RIV3, trivalent recombinant (non-live) influenza vaccine; SD-IIV, inactivated (non-live) egg-based influenza vaccine; WHO, World Health Organization.

INTRODUCTION

Children, especially younger than 5 years and those with certain underlying medical conditions, can experience substantial morbidity, including severe or fatal complications, from influenza virus

infection.¹⁻³ Children also play a pivotal role in transmission of influenza virus infection to household members and other close contacts.⁴⁻⁶

Influenza vaccination of children can reduce disease burden directly and among household members, close contacts, and community members of all ages.^{7,8} By reducing the burden of respiratory illnesses, influenza vaccination helps to preserve health care capacity, especially when other viruses are cocirculating.

The American Academy of Pediatrics (AAP) recommends routine influenza vaccination of all children ≥ 6 months of age. Despite this recommendation, influenza vaccination coverage remained low during the 2025–2026 influenza season. Through May 16, 2026, only 49.4% of children 6 months through 17 years had been vaccinated, similar to the previous year (<https://www.cdc.gov/fluview/dashboard/children-vaccination-coverage.html>). Differences in vaccination rates were noted by age, race, and ethnicity; poverty status; urbanicity; and maternal educational status.⁹ Continued efforts to increase influenza vaccination, including strategies to decrease disparities in vaccine access and delivery and to counter vaccine hesitancy, are urgently needed.

This policy statement summarizes updates and recommendations for the 2026–2027 influenza season. A technical report provides further detail.¹⁰

UPDATES FOR THE 2026–2027 INFLUENZA SEASON

1. All licensed vaccines available in the United States this season are trivalent.
2. The compositions of influenza vaccines for the 2026–2027 season have been updated (Table 1).
3. Afluria is no longer available.
4. Recommendations for influenza immunization of immunocompromised hosts have been updated to align with evidence-based recommendations from other groups and professional societies.¹¹⁻¹⁵
5. On January 9, 2026, the US Food and Drug Administration (FDA) advised influenza vaccine manufacturers to update prescribing information with the following statement¹⁶: *In two separate postmarketing observational studies, an increased risk of febrile seizures was observed during*

the first day following vaccination with standard dose trivalent (2024-2025) and quadrivalent (2023-2024) influenza vaccines in children 6 months through 4 years of age. The magnitude of the attributable risk is low (estimated 1 excess febrile seizure episodes per 47,170 doses of quadrivalent vaccine and 1 excess febrile seizure per 22,624 doses of trivalent vaccinations).¹⁷

The package inserts for IIVs were updated.

6. Recommendations for influenza treatment and prophylaxis have been clarified, emphasizing that chemoprophylaxis is not generally indicated for infants younger than 3 months.
7. Baloxavir tablets are available as a generic formulation beginning with the 2026-2027 season.¹⁸
8. On August 5, 2026, the FDA approved an mRNA influenza vaccine (mFLUSIVA) for use in adults 50 years and older. The vaccine is not indicated for use in children.

Table 1. Trivalent Influenza Vaccine Composition for the 2026–2027 Season

	Specific Strain
Influenza A	
H1N1	A/Missouri/11/2025 (H1N1)pdm09-like virus (egg-based) ^a
	A/Missouri/11/2025 (H1N1)pdm09-like virus; (cell culture-based or recombinant) ^a
H3N2	A/Darwin/1454/2025 (H3N2)-like virus (egg-based) ^a
	A/Darwin/1415/2025 (H3N2)-like virus (cell culture-based or recombinant) ^a
Influenza B	
Victoria	B/Tokyo/EIS13-175/2025 (B/Victoria lineage)-like virus (egg-based) ^a
	B/Pennsylvania/14/2025 (B/Victoria lineage)-like virus (cell culture-based or recombinant) ^a

Quadrivalent vaccines are still available outside the United States.

^a New this season.

HIGH-RISK GROUPS IN PEDIATRICS

Children with certain underlying medical conditions are at increased risk of hospitalization and complications attributable to influenza; children younger than 5 years are also at increased risk, although the risk is highest in children younger than 2 years (Table 2).¹⁰ Although influenza vaccination is recommended for everyone starting at 6 months of age, emphasis should be placed on ensuring that high-risk children, as well as their

parents/guardians, other household contacts, and all caregivers receive annual influenza vaccine (Table 3).

Table 2. High-Risk Groups for Influenza Complications

Category	Description
Demographic characteristics	Children <5 y, especially those <2 y ^a
	Children born preterm or early term ^b
	Residents of a chronic care facility or nursing home
Underlying Condition or Treatment with Common Examples^c	
Chronic pulmonary disease	Asthma ¹⁹
	Cystic fibrosis
	Bronchopulmonary dysplasia ¹⁹
	Compromised respiratory function (eg, requiring mechanical ventilation, tracheostomy)
Cardiovascular disease	Hemodynamically significant conditions (excluding hypertension alone)
Kidney disease	Chronic kidney disease, including end-stage kidney disease
	Dialysis
Hepatic disease	Chronic liver disease
	Cirrhosis ^{20,21}
Hematologic disease	Sickle cell disease
	Other hemoglobinopathies
Metabolic disorders	Diabetes mellitus
Neurologic and neurodevelopmental conditions	Cerebral palsy
	Epilepsy
	Stroke
	Intellectual developmental disorder
	Moderate to severe developmental delay
	Neuromuscular disorders, including muscular dystrophy
	Spinal cord injury
Extreme obesity	BMI ≥40 for adults; BMI ≥the 95th percentile in children ^d
Immunosuppression	Receipt of immunocompromising medications
	Receipt of hematopoietic cell transplant or solid organ transplant
	Congenital or acquired immune deficiency, including HIV
	Asplenia
Receiving treatment with aspirin or salicylate-containing therapies ^e	
Pregnancy and up to 2 weeks postpartum	

Abbreviation: BMI, body mass index.

^a Regardless of the presence of underlying medical conditions.

^b Children who were born preterm (birth at <37 weeks' gestation) or early term (birth at 37 or 38 weeks' gestation) are at higher risk of influenza hospitalization in the first 5 years of life.²

^c List of examples is not exhaustive.

^d Body mass index (BMI) associated with increased risk not well-defined in children but could consider BMI at or above the 95th percentile for children and adolescents of the same age and sex.^{22,23}

^e Applies to children and adolescents <19 years who may be at increased risk of Reye syndrome.

Table 3. Strategies for Increasing Childhood Influenza Vaccination

Pediatric Care Team
• Offer strong, presumptive influenza vaccine recommendation • Bundle recommendation for influenza vaccine with recommendations for other needed vaccines • Use consistent messaging across care team members • Identify influenza vaccine champion(s)
Practice/Health System
• Review influenza vaccination status at all visits • Bundle influenza vaccine with other needed vaccines • Vaccinate at all visit types (eg, well child, acute care visits) • Vaccinate in all health care settings (eg, hospital, emergency department, subspecialty practice) • Increase access to influenza vaccine (eg, expanded hours, vaccine-only clinic) • Provide evidence-based information to patients and families (eg, office-based educational handout) • Offer scripting for staff and messaging for patients and families to address common questions, including frequent misconceptions and relevant contraindications and precautions^a • Consider an early or expedited allergy referral for patients with a potential flu vaccine allergy to ensure timely vaccination when appropriate • Send influenza vaccine reminder/recall messages^b • Use electronic health record (EHR)-based tools to identify high-risk patients for targeted outreach • Utilize standing orders for influenza vaccine • Implement influenza vaccine prompts/clinical decision support • Perform audits and share feedback reports
Community/Public Health
• Integrate electronic health record with regional or state immunization information system (IIS) and automate reconciliation of electronically received influenza vaccine administration data • Partner with key parties to support vaccine initiatives within the community, including school-based programs and pharmacies • Engage with communities affected by health disparities to develop tailored strategies that promote trust, encourage dialogue, and increase access to preventive services

^a AAP resources include a Flu Campaign Toolkit (<https://www.aap.org/en/news-room/campaigns-and-toolkits/flu-campaign-toolkit/>), discussion guides for influenza vaccine and other vaccines that protect against respiratory illness (<https://www.aap.org/en/patient-care/immunizations/childhood-immunization-discussion-guides/>), and recommendations for communicating with families about vaccines and promoting vaccine confidence (<https://www.aap.org/vaccinecommunication>).

^b Reminder and recall strategies as well as downloadable, customizable reminder and recall resources are available at <https://www.aap.org/en/patient-care/immunizations/implementing-immunization-administration-in-your-practice/reminder-and-recall-strategies>.

Increased efforts are needed to eliminate barriers to vaccination in all persons experiencing higher rates of adverse outcomes from influenza. Racial and ethnic disparities exist in severe outcomes from influenza.²⁴ In a cross-sectional study spanning 10 influenza seasons, higher rates of influenza-associated hospitalizations and intensive care unit admissions were observed in Black, Hispanic, and American Indian/Alaska Native people, and disparities were highest in children ≤ 4 years of age.²⁴ Influenza-associated in-hospital deaths were three- to fourfold higher in Black, Hispanic, and Asian/Pacific Islander children compared with white children.²⁴ Inequities in health care system access and other social drivers of health may contribute to severe outcomes and increased mortality in these groups.

SEASONAL INFLUENZA VACCINES

The seasonal influenza vaccines licensed for children for the 2026–2027 season are described in Table 4. As in the 2025–2026 season, all 2026–2027 seasonal influenza vaccines available in the United States are trivalent and contain hemagglutinin derived from the same influenza strains as recommended by the World Health Organization (WHO) and the FDA for the Northern Hemisphere (Table 1).^{25,26}

Table 4. Recommended Seasonal Influenza Vaccines for Children and Adolescents: United States, 2026–2027 Influenza Season

Vaccine	Trade Name (Manufacturer)	Age Group	Presentation and Hemagglutinin Antigen Content (IIVs and RIV3) or Virus Count (LAIV3) per Dose for Each Antigen	Recommended Dose	Thimerosal Mercury Content ^a (mcg Hg/0.5-mL dose)
Trivalent Standard Dose – Egg-Based Vaccines					
SD-IIV3	Fluarix (GlaxoSmithKline)	≥6 mo	0.5-mL prefilled syringe (15 mcg/0.5 mL)	0.5 mL	0
SD-IIV3	FluLaval (GlaxoSmithKline)	≥6 mo	0.5-mL prefilled syringe (15 mcg/0.5 mL)	0.5 mL	0
SD-IIV3	Fluzone (Sanofi Pasteur)	≥6 mo	0.5-mL prefilled syringe (15 mcg/0.5 mL)	0.5 mL	0
		6 through 35 mo	5-mL multidose vial ^{b,c} (15 mcg/0.5 mL)	0.25 or 0.5 mL	25
		≥36 mo	5-mL multidose vial ^b (15 mcg/0.5 mL)	0.5 mL	25
Trivalent High Dose – Egg-Based Vaccines					
HD-IIV 3	Fluzone High-Dose (Sanofi Pasteur)	≥65 y ^d	0.5-mL prefilled syringe (60 mcg/0.5 mL)	0.5 mL	0
Trivalent Standard Dose – Cell Culture-Based Vaccines					
ccIIV3	Flucelvax (Seqirus)	≥6 mo	0.5-mL prefilled syringe (15 mcg/0.5 mL)	0.5 mL	0
Recombinant Vaccine					
RIV3	Flublok (Sanofi Pasteur)	≥9 y	0.5-mL prefilled syringe (45 mcg/0.5 mL)	0.5 mL	0
Live Attenuated Vaccine-Egg Based Vaccine					
LAIV3	FluMist (AstraZeneca)	2–49 y	0.2-mL prefilled intranasal sprayer (virus dose: 10 ^{6.5–7.5} FFU/0.2 mL) 10 pack for health care provider office use -single pack for home use available through online pharmacy	0.2 mL (0.1 mL per nostril)	0

Prepublication Release

Abbreviations: IIV3, trivalent adjuvanted inactivated (non-live) influenza vaccine; ccIIV3, trivalent cell culture-based inactivated (non-live) influenza vaccine; FFU, fluorescent focus unit; LAIV3, trivalent live attenuated influenza vaccine; RIV3, trivalent recombinant (non-live) influenza vaccine.

^a See section on Thimerosal-Containing Vaccines.

^b For vaccines that include a multidose vial presentation, the maximum number of doses withdrawn should not exceed the number specified in the package insert (eg, 10 doses for Fluzone). Residual product should be discarded.

^c A total of 0.25 mL drawn from a multidose vial is an acceptable dose for children 6 to 35 months of age. Implementation guidance on supply, pricing, payment, billing, coding, and liability issues can be found at aap.org/influenza.

^d High dose not currently FDA-approved for use in children. Consider administration of 2 doses of high-dose IIV, 28 to 42 days apart, in pediatric hematopoietic cell transplant (HCT) recipients 3 to 17 years of age during first year after HCT.

INFLUENZA VACCINE RECOMMENDATIONS

General Recommendations

1. The AAP recommends influenza vaccination for individuals 6 months and older every influenza season.
2. The AAP recommends any licensed influenza vaccine product appropriate for age and health status and does not prefer one product over another, including inactivated (non-live) egg-based influenza vaccine (SD-IIV), inactivated (non-live) cell culture-based influenza vaccine (ccIIV), recombinant influenza vaccine (RIV), and live attenuated influenza vaccine (LAIV). Influenza vaccination should not be delayed to obtain a specific product, including a thimerosal-free product. The safety of thimerosal-containing vaccines is discussed in the technical report (<https://doi.org/10.1542/peds.2026-078779>).
3. LAIV should not be used for immunocompromised persons and persons with certain chronic medical conditions (Table 5).
4. The number of influenza vaccine doses recommended for children remains unchanged in the 2026–2027 influenza season and depends on the child’s age at first dose administration and influenza vaccination history (Figure 1). Doses given up to 4 days prior to the minimum suggested interval are considered valid.

Table 5. Influenza Vaccine Contraindications and Precautions

Vaccine	Contraindication	Precaution	Pediatric Care Team Discretion	Not Contraindication or Precaution
Inactivated (non-live) egg-based influenza vaccine—(SD-IIV) ^a	Anaphylaxis or severe allergic reaction to any previous influenza vaccination or to any vaccine component	- Moderate to severe acute illness, with or without fever - History of Guillain-Barré syndrome (GBS) within 6 weeks of prior influenza vaccination		- Mild illness, with or without fever - Egg allergy
Inactivated (non-live) cell culture-based influenza vaccine (ccIIV) ^a	Anaphylaxis or severe allergic reaction to previous dose of ccIIV or any component of ccIIV³	- Moderate to severe acute illness, with or without fever - History of GBS within 6 weeks of prior influenza vaccination - Anaphylaxis or severe allergic reaction to any other influenza vaccine (ie, any egg-based IIV, LAIV, or RIV)		- Mild illness, with or without fever - Egg allergy
Live attenuated influenza vaccine (LAIV) ^a	- Anaphylaxis or severe allergic reaction to any previous influenza vaccination or to any vaccine component, including gelatin - Taking aspirin or salicylate-containing medications - Age 2–4 y with diagnosis of asthma or history of wheezing in last 12 mo - Cochlear implants - Active cerebrospinal fluid leaks - Immunosuppression attributable to any cause, including: - Primary or acquired immunodeficiency, including HIV - Immunosuppressive or immunomodulatory therapy - Anatomic or functional asplenia - Close contacts or caregivers of severely immunocompromised individuals - Receiving or recently received influenza antiviral medication^b - Currently pregnant^c	- Moderate to severe acute illness with or without fever, - History of GBS within 6 weeks of prior influenza vaccination - Diagnosis of asthma and age ≥ 5 y - Certain underlying chronic conditions that might predispose to complications after influenza (eg, chronic pulmonary disease, cardiovascular disease, renal, hepatic, neurologic, hematologic, or metabolic disorders)	Defer to resolution of symptoms or use IIV if a patient has nasal congestion that could impede vaccine delivery	- Mild illness, with or without fever - Egg allergy

Vaccine	Contraindication	Precaution	Pediatric Care Team Discretion	Not Contraindication or Precaution
Recombinant (non-live) hemagglutinin vaccine (RIV3) ^a	Anaphylaxis or severe allergic reaction to previous dose of RIV3 or any component of RIV3	- Moderate to severe illness, with or without fever - History of GBS within 6 weeks of prior influenza vaccination - Anaphylaxis or severe allergic reaction to any other influenza vaccine (ie, any egg-based IIV, LAIV, or ccIIV)		- Mild illness, with or without fever - Egg allergy

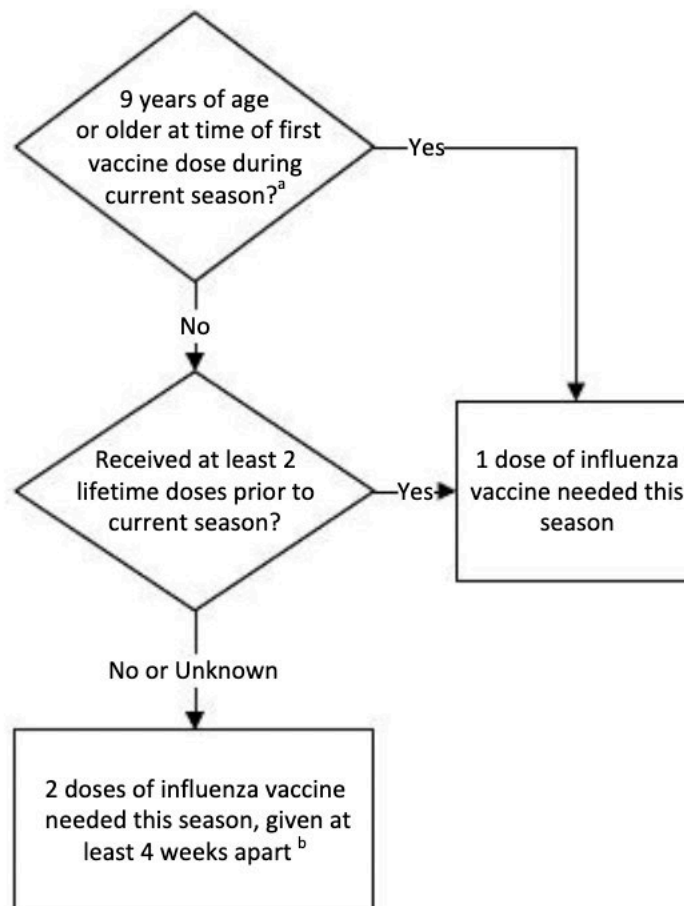
^a Egg-based IIVs for children include Fluarix, FluLaval, and Fluzone. Cell-culture based IIV includes Flucelvax.

RIV includes Flublok. LAIV includes FluMist.

^b Within 48 hours (oseltamivir, zanamivir), 5 days (peramivir), or 17 days (baloxavir) of stopping influenza antiviral therapy.

^c Pregnancy is not a labeled contraindication for LAIV. The prescribing information for FluMist Quadrivalent, 2023–2024 formula indicated that FluMist is not absorbed systemically following intranasal administration, and use during pregnancy is not expected to result in fetal exposure to the drug.

Figure 1. Number of 2026–2027 seasonal influenza vaccine doses recommended for children based on age and prior vaccination history



^a Must be at least 6 months of age to be eligible for influenza vaccine.

^b Second dose still required for children who turn 9 between first and second dose. The same vaccine formulation is not required for the first and second dose.

5. When a child is recommended to receive 2 doses of vaccine in the same influenza season, the doses do not need to be the same brand or formulation. A child may receive a combination of IIV (SD-IIV or ccIIV), RIV, and LAIV if appropriate for age and health status.
6. Influenza vaccine should be offered to children as soon as it becomes available, especially to those recommended to receive 2 doses. The recommended dose(s) ideally should be received by the end of October for optimal protection before the influenza season.

Recommendations for Immunocompromised Children

7. For moderately to severely immunocompromised children, provide age-appropriate influenza vaccination (IIV or RIV) before the start of influenza season when possible.
8. For children with malignancy receiving chemotherapy, administer IIV or RIV ≥ 2 weeks before cytotoxic chemotherapy when possible.
9. For children receiving immunosuppression for underlying autoimmune or autoinflammatory conditions, administer IIV or RIV at least ≥ 2 weeks before starting these therapies when possible.
10. For children who will be starting anti-B cell therapies (eg, rituximab, alemtuzumab), administer IIV or RIV ≥ 2 weeks before starting these therapies when possible.
11. For children who have received B-lymphocyte-depleting therapies, consider IIV or RIV ≥ 3 to 6 months after last dose; earlier vaccination could be considered if influenza is circulating in the community.^{13,15}
12. For children who have received CD19-targeted chimeric antigen receptor T-lymphocyte infusions (CAR-T), consider IIV or RIV ≥ 3 to 6 months after CAR-T in patients who are in remission and do not require additional intensive chemotherapy or hematopoietic cell transplant (HCT).^{13,14}
13. For HCT recipients, consider IIV or RIV starting ≥ 3 months after HCT.^{11,13,15}
14. Consider administering 2 doses of high-dose IIV 28 to 42 days apart in pediatric HCT recipients 3 to 17 years of age in the first year after HCT, recognizing that high-dose IIV is not approved for use in children.^{27,28}

15. For solid organ transplant (SOT) recipients 6 months through 17 years of age, consider IIV or RIV ≥ 1 month after transplantation.^{12,13} For SOT recipients 18 years and older receiving immunosuppressive medications, HD or aIIV are acceptable options.^{29,30}
16. For children living with HIV infection, administer age-appropriate influenza vaccination (IIV or RIV) before the start of influenza season when possible.¹³
17. Household and close contacts of immunocompromised patients should be up-to-date with influenza vaccination.

Additional Recommendations for Pregnant and Breastfeeding Persons During Influenza Seasons

18. Influenza vaccination is recommended for pregnant individuals to benefit both them and their infants. IIV, ccIIV, or RIV can be given at any time during pregnancy. Those who do not receive it during pregnancy should receive influenza vaccine before hospital discharge. Those who decline the vaccine during hospitalization should be encouraged to discuss influenza vaccination with their obstetrician, primary care physician, nurse midwife, or other qualified medical professional.
19. Influenza vaccination of a breastfeeding parent provides protection to both the parent and the infant, is recommended, and is safe.

Additional Recommendations for Travelers

20. Individuals traveling to the tropics, on cruise ships, to the Southern hemisphere, or to other places where influenza may be circulating during April to September should consider seasonal influenza vaccination ≥ 2 weeks before departure if not vaccinated during the preceding fall or winter and if vaccine is available (see technical report [<https://doi.org/10.1542/peds.2026-078779>]).¹⁰

Additional Recommendations for Health Care Personnel

21. Annual influenza vaccination of health care personnel is recommended as a condition of employment as a crucial strategy for reducing health care-associated influenza virus infections.

Influenza Vaccine Implementation

22. Efforts should be made to promote influenza vaccination of all children, especially children younger than 5 years and those in other high-risk groups (Table 2) and their contacts, unless contraindicated (Table 5), using evidence-based strategies (Table 3). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in development of culturally relevant strategies.
23. Strategies for communicating with families about vaccines and promoting vaccine confidence are available (<https://www.aap.org/vaccinecommunication>).
24. Increasing access and reducing barriers to vaccination through schools, pharmacies, hospitals, and other nontraditional settings may improve vaccination rates. However, vaccination in the medical home is preferred for young children to facilitate other necessary services, including well care, preventive screening, anticipatory guidance, and other important childhood vaccinations. For patients and families for whom resource constraints would present an obstacle to vaccination in the medical home, at-home administration of LAIV is an alternative for some eligible individuals 2 through 49 years of age. Practical considerations for LAIV administered at home are presented in the technical report (<https://doi.org/10.1542/peds.2026-078779>).¹⁰
25. When influenza vaccination occurs outside the medical home, documentation should be provided to patients, shared with the medical home and submitted to required state or regional immunization information systems (IISs).
26. Practices serving children and adolescents may consider offering influenza vaccine to family members and close contacts.³¹

Influenza Vaccine Advocacy

27. Public and private payers should offer adequate payment for influenza vaccine administration to pediatric populations, update policies so that doses administered in July and August are covered, and eliminate “patient responsibility” cost barriers to influenza vaccination.

28. All participants in immunization efforts should work to eliminate disparities in influenza vaccine supply between privately insured patients and those eligible for vaccination through the Vaccines for Children (VFC) program. Pediatricians and other primary care pediatric providers in areas where borrowing is allowed between VFC and non-VFC supplies should be aware of these policies and leverage them to address disparities in availability (permissibility of borrowing should be confirmed in advance).
29. Information about influenza vaccine and influenza vaccine clinics should be provided to eligible children and their families in their preferred language.

INFLUENZA VACCINE CONTRAINDICATIONS AND PRECAUTIONS

Contraindications and precautions for use of influenza vaccines are described in Table 5, and further details are provided in the technical report.¹⁰ Key points include:

1. Product-specific contraindications must be considered when selecting the type of influenza vaccine to administer.³²
2. Although a history of severe allergic reaction (eg, anaphylaxis) to any influenza vaccine is generally a contraindication to future receipt of influenza vaccines, children who have had a severe allergic reaction after influenza vaccination should be evaluated by an allergist to help identify the vaccine component responsible for the reaction and to determine whether future vaccination is appropriate. Children who are allergic to gelatin (very rare) should receive IIV (or RIV if age appropriate) instead of LAIV. Overlap between gelatin and alpha-gal allergy has been reported.³³
3. Children with egg allergy of any severity, including anaphylaxis, can receive any influenza vaccine without any additional precautions beyond those recommended for all vaccines.
4. Children with acute moderate or severe illness may receive influenza vaccine as soon as their acute illness has improved; strategies to promote timely receipt once recovered from illness should be employed (ie, schedule return visit; send reminder message; administer prior to

discharge from hospital setting); children with mild illness, including a low-grade fever, should still be vaccinated.

5. History of seizures or febrile seizures is not a precaution or contraindication to receipt of influenza vaccine.

INFLUENZA TESTING

Influenza Testing Recommendations Are Informed by Setting and Anticipated Impact on Clinical Management

1. Influenza testing should be performed in children with signs and symptoms of influenza when test results are anticipated to impact clinical management (eg, to inform the discussion of initiating antivirals, avoid antibiotic therapy, pursue other diagnostic testing, initiate infection prevention and control measures, or distinguish from other respiratory viruses with similar symptoms). A list of FDA-cleared and -authorized tests is available at <https://www.fda.gov/medical-devices/in-vitro-diagnostics/influenza-diagnostic-tests>.
2. When influenza is circulating in the community, hospitalized patients with signs and symptoms of influenza should be tested with a nucleic acid amplification test with high sensitivity and specificity (eg, reverse transcriptase-polymerase chain reaction [RT-PCR]) to inform treatment and infection control practices.
3. At-home tests are available for children as young as 6 months (<https://www.fda.gov/medical-devices/in-vitro-diagnostics/influenza-diagnostic-tests>), but data on use of these tests in pediatric patients are limited. Use of at-home test results to inform treatment decisions should be informed by sensitivity and specificity of the test, prevalence of influenza in the community, presence and duration of compatible signs and symptoms, and individual risk factors and comorbidities.
4. Testing for avian influenza such as influenza A (H5N1) or other novel strains should be performed at the direction of public health authorities.³⁴ Pediatricians and other pediatric

professionals should consider asking about exposures to sick or dead animals, particularly wild birds, poultry, or dairy cows, to inform the need for testing for avian influenza.

INFLUENZA TREATMENT

Antiviral medications (Table 6) are an important adjunct in the control of influenza but are not a substitute for influenza vaccination. The role of antivirals for prevention and treatment of influenza in children depends on illness severity and risk considerations (Table 7). Options for antiviral medications along with potential benefits and harms of antiviral treatment are summarized in the technical report (<https://doi.org/10.1542/peds.2026-078779>).¹⁰ Although best results are observed when the child is treated within 48 hours of symptom onset, antivirals may be offered beyond 48 hours in certain cases.

1. Pediatricians and other pediatric care professionals should promptly identify patients suspected of having influenza for timely initiation of antiviral treatment, when indicated, to reduce morbidity and mortality. In the ambulatory setting, treatment of children who are not at high risk for influenza complications can be considered with a discussion of benefits and risks of treatment with the parent/guardian.
2. Provision of antiviral therapy does not require a positive test for influenza when influenza is circulating in the community. Initiation of antiviral therapy should be based on signs and symptoms consistent with influenza infection, patient risk factors, and epidemiologic factors (eg, influenza circulating in the community, known exposure, etc).
3. The AAP considers oseltamivir the preferred antiviral for patients with influenza A and B because of the cumulative experience of this drug in children, relative to efficacy, safety, cost, and ease of administration. Pediatricians should refer to the Centers for Disease Control and Prevention (CDC [https://www.cdc.gov/flu/hcp/antivirals/summary-clinicians.html#cdc_generic_section_9-influenza-antiviral-resistance-considerations]) for the most up-to-date information on antiviral susceptibilities. AAP and CDC recommendations for the use of oseltamivir differ from FDA-approved labeling. The FDA has approved oseltamivir for

treatment of children as young as 2 weeks of age. Given preliminary pharmacokinetic data and limited safety data, the CDC and AAP support the use of oseltamivir to *treat* influenza in both term and preterm infants from birth, because benefits of therapy for neonatal influenza are likely to outweigh possible risks of treatment.

Recommendations for Treatment and Chemoprophylaxis of Specific Populations

4. Recommend antiviral treatment as early as possible to the following individuals, regardless of influenza vaccination status and duration of symptoms¹:
 - Any child hospitalized because of suspected or confirmed influenza disease.
 - Any child with severe, complicated, or progressive influenza disease, regardless of health care setting (ie, inpatient or ambulatory).
 - Any child with suspected or confirmed influenza disease of any severity younger than 5 years or belonging to other high-risk groups for influenza complications, regardless of health care setting (ie, inpatient or ambulatory) (Table 2).
5. Treatment is an option for the following individuals in the ambulatory setting:
 - Any child with suspected or confirmed influenza disease who is not at high risk for influenza complications, if treatment can be initiated within 48 hours of illness onset.
 - Any child with suspected or confirmed influenza disease whose siblings or household contacts are at high risk for influenza complications (Table 2).

Table 6. Recommended Dosage and Schedule of Influenza Antiviral Medications for Treatment and Chemoprophylaxis in Children for the 2026-2027 Influenza Season: United States

Chemoprophylaxis in Children for the 2018-2019 Influenza Season, United States					
Medication	Treatment		Chemoprophylaxis		Common Adverse Events ^a
	Dosage	Duration	Dosage	Duration After Last Exposure	
Oseltamivir ^{b,c} (Given orally or by feeding tube)					
Adults	75 mg, twice daily	5 d	75 mg, once daily	7 d	Nausea Vomiting Headache
Children ≥12 mo					
>40 kg	75 mg, twice daily	5 d	75 mg, once daily	7 d	Nausea
>23 kg–40 kg	60 mg, twice daily	5 d	60 mg, once daily	7 d	Vomiting
>15 kg–23 kg	45 mg, twice daily	5 d	45 mg, once daily	7 d	Headache

Medication	Treatment		Chemoprophylaxis		Common Adverse Events ^a
	Dosage	Duration	Dosage	Duration After Last Exposure	
≤15 kg	30 mg, twice daily	5 d	30 mg, once daily	7 d	Vomiting Skin reactions Diarrhea (children <1 y of age)
All Infants 9–11 mo ^d	3.5 mg/kg per dose, twice daily	5 d	3.5 mg/kg per dose, once daily	7 d	
Term infants 3–8 mo ^d	3 mg/kg per dose, twice daily	5 d	3 mg/kg per dose, once daily	7 d	
Term infants 0–<3 mo ^d	3 mg/kg per dose, twice daily	5 d	Not Recommended		
Preterm infants 0–8 mo ^c					
>40 weeks postmenstrual age (PMA)	3 mg/kg per dose, twice daily	5 d	See footnote		
38–40 weeks PMA	1.5 mg/kg per dose, twice daily	5 d			
<38 weeks PMA	1 mg/kg per dose, twice daily	5 d			
Zanamivir ^{c,f} (Given via inhalation)					
Adults	10 mg (two 5-mg inhalations), twice daily	5 d	10 mg (two 5-mg inhalations), once daily	7 d ^c	Bronchospasm Skin reactions
Children ≥7 y	10 mg (two 5-mg inhalations), twice daily	5 d	10 mg (two 5-mg inhalations), once daily	7 d ^b	Sinusitis Dizziness
Children 5–7 y	Not recommended		10 mg (two 5-mg inhalations), once daily	7 d ^b	
Peramivir ^g (Given via intravenous infusion over 15-30 minutes)					
Adults	One 600-mg dose	N/A	Not recommended		Diarrhea
Children 13–17 y	One 600-mg dose	N/A			
Children 6 mo–12 y	One 12-mg/kg dose (600 mg maximum)	N/A			
Baloxavir ^h (Given orally or by feeding tube)					
Individuals ≥5 y					
≥80 kg	One 80-mg dose	N/A	One 80-mg dose	N/A	Nausea, vomiting, and diarrhea, similar to placebo
20 kg–<80 kg	One 40-mg dose	N/A	One 40-mg dose	N/A	
<20 kg	One 2-mg/kg dose	N/A	2 mg/kg as single dose	N/A	

^a Although only common adverse events are listed in this table, there are postmarketing reports of serious skin reactions with oseltamivir, peramivir, and zanamivir.

^b Oseltamivir is administered without regard to meals, although administration with meals may improve gastrointestinal tolerability. Oseltamivir is available as 30-mg, 45-mg, and 75-mg capsules and as a powder for oral suspension that is reconstituted to provide a final concentration of 6 mg/mL. For the 6-mg/mL suspension, a 30-mg dose is given with 5 mL of oral suspension, a 45-mg dose is given with 7.5 mL oral suspension, a 60-mg dose is given with 10 mL oral suspension, and a 75-mg dose is given with 12.5 mL oral suspension. If the commercially manufactured oral suspension is not available, a suspension can be compounded by retail pharmacies (final concentration also 6 mg/mL), based on instructions contained in the package label. For infants younger than 1 year, an appropriate measuring device such as a 3-mL or 5-mL oral syringe should be used to measure the dose instead of the syringe supplied.

In patients with renal insufficiency, the dose should be adjusted on the basis of creatinine clearance. Renal dosing of oseltamivir is not available in the package insert (https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021087s062lbl.pdf) for pediatric patients.

However, the package insert instructions may be useful for children who qualify for adult doses based on weight >40 kg. For treatment of patients with creatinine clearance 10–30 mL/min: 75 mg, once daily, for 5 days. For chemoprophylaxis of patients with creatinine clearance 10–30 mL/min: 30 mg, once daily, for 10 days after exposure or 75 mg, once every other day, for 10 days after exposure (5 doses).

^c The Centers for Disease Control and Prevention (CDC) recommends routine chemoprophylaxis with oseltamivir or zanamivir for 7 days after last known exposure; minimum of 14 days and continuing for 7 days after last known exposure if part of institutional outbreak (<https://www.cdc.gov/flu/hcp/antivirals/summary-clinicians.html>). This differs from the approved US Food and Drug Administration (FDA) labeling for oseltamivir, which recommends prophylaxis for 10 days following close contact with an infected individual and up to 6 weeks during a community outbreak. This also differs from the package insert for zanamivir, which recommends prophylaxis for 10 days in community settings and 28 days in community outbreaks (https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/021036s025lbl.pdf).

^d Approved by the FDA for treatment of children as young as 2 weeks of age. Given preliminary pharmacokinetic data and limited safety data, oseltamivir can be used to treat influenza in both term and preterm infants from birth, because benefits of therapy are likely to outweigh possible risks of treatment. Oseltamivir is not FDA-approved for postexposure prophylaxis (PEP) in children younger than 1 year. Oseltamivir is not recommended by the American Academy of Pediatrics (AAP) or CDC for chemoprophylaxis of infants <3 months of age because of limited safety and efficacy data in this age group. Of note, the dose recommended by the AAP for treatment of infants 9 to 11 months of age is higher than the FDA-approved dose of 3.0 mg/kg, twice daily, and is based on data that indicated that the higher dose was needed to achieve the protocol-defined targeted exposure for infants in this age group, as defined in the National Institute of Allergy and Infectious Diseases Collaborative Antiviral Study Group 114 study.³⁵ The CDC recommends a dose of 3.0 mg/kg, twice daily, for all infants <12 months of age; the Infectious Diseases Society of America (IDSA) guidelines³⁶ include both AAP and CDC recommendations.

^e Oseltamivir dosing for preterm infants: weight-based dosing recommendation for preterm infants is lower than for term infants.^{37–39} Preterm infants may have lower clearance of oseltamivir because of immature renal function, and doses recommended for full-term infants may lead to very high drug concentrations in this age group. Limited data from the National Institute of Allergy and Infectious Diseases Collaborative Antiviral Study Group provide the basis for dosing preterm infants using their postmenstrual age (PMA) (gestational age + chronologic age). For extremely preterm infants (<28 weeks), please consult a pediatric infectious disease physician. PEP is not generally recommended for preterm infants because of limited data on use in these infants unless PEP is determined to be essential for outbreak control based on pediatric care team judgment. Optimal dosing has not been defined in this circumstance.

^f Zanamivir is administered by inhalation using a proprietary “Diskhaler” device distributed together with the medication. Zanamivir is a dry powder, not an aerosol, and should not be administered using nebulizers, ventilators, or other devices typically used for administering medications in aerosolized solutions. Zanamivir is not recommended for people with chronic respiratory diseases, such as asthma or chronic obstructive pulmonary disease, which increase the risk of bronchospasm.

^g Peramivir requires dose adjustment in patients with renal insufficiency. For treatment of pediatric patients 2 to 12 years of age: 2 mg/kg if creatinine clearance is 10–29 mL/min; 4 mg/kg if creatinine clearance is 30 to 49 mL/min; 12 mg/kg if creatinine clearance is ≥50 mL/min up to a maximum of 600 mg. For treatment of adolescents 13 years and older, 100 mg if creatinine clearance is 10–29 mL/min; 200 mg if creatinine clearance is 30 to 49 mL/min; 600 mg if creatinine clearance is ≥50 mL/min. No data are available to inform a recommendation for dosage adjustment with peramivir in pediatric patients 6 months to less than 2 years of age with creatinine clearance less than 50 mL/min (https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/206426s009lbl.pdf).

^h Oral baloxavir marboxil is approved by the FDA for treatment of acute uncomplicated influenza within 2 days of illness onset. It should not be administered with dairy products, calcium-fortified beverages, polyvalent cation-containing laxatives, antacids, or oral supplements (eg, calcium, iron, magnesium, selenium, or zinc). Baloxavir marboxil is not recommended as monotherapy for treatment of influenza in individuals who are severely immunocompromised. It is not recommended for persons who are pregnant or breastfeeding.

Sources: IDSA³⁶ and <https://www.cdc.gov/flu/hcp/antivirals/summary-clinicians.html>.

Table 7. Summary of Antiviral Treatment and Chemoprophylaxis Recommendations

Treatment for Symptomatic Disease			
Symptomatic Child	- Hospitalized children - Children with severe, complicated, or progressive illness - Children at higher risk for complications (Table 2)	No time limit on starting, although treatment should ideally be started as soon as possible after symptom onset	Recommend treatment
	- Children with household contacts at high risk because of underlying medical condition - Children with household contacts younger than 6 months		Consider treatment
	Children with mild to moderate influenza-like symptoms without other risk factors	Within 48 hours of symptoms starting	Consider treatment
Chemoprophylaxis^a for Asymptomatic Exposures			
Exposed, Asymptomatic Child	- Unvaccinated or incompletely vaccinated children at high risk of complications - Vaccinated children at high risk of complications who may have not mounted an immune response - Vaccinated children at high risk of complications when vaccination strain does not match or is ineffective against circulating strains - Unvaccinated children with a family member or close contact at high risk for influenza complications and is unable to be otherwise effectively protected	Within 48 hours of exposure	Consider chemoprophylaxis
Exposed Close Contact	- Unvaccinated family members and close contacts of unvaccinated children at high risk of complications - Vaccinated family members and close contacts of children at high risk of complications when vaccination strain does not match or is ineffective against circulating strains	Within 48 hours of exposure	Consider chemoprophylaxis

^a Chemoprophylaxis is not generally indicated for children <3 months of age.

INFLUENZA CHEMOPROPHYLAXIS RECOMMENDATIONS

1. The AAP considers oseltamivir to be the preferred postexposure chemoprophylaxis for influenza A and/or B when chemoprophylaxis is indicated.
2. Chemoprophylaxis is not generally recommended in infants younger than 3 months unless the situation is judged critical because of limited safety and efficacy data in this age group.
3. Chemoprophylaxis is not a substitute for vaccination.

4. Postexposure chemoprophylaxis should only be used when antiviral agents can be initiated within 48 hours of exposure.
5. Postexposure chemoprophylaxis should not be used routinely outside of institutional outbreaks.
6. Postexposure chemoprophylaxis is recommended for unvaccinated staff and unvaccinated children in a closed institutional setting with children at high risk for influenza complications (eg, extended-care facilities) to control influenza outbreaks.
7. Postexposure chemoprophylaxis can otherwise be considered at the individual level after known or suspected influenza exposure for children in the following situations:
 - Any child at high risk for influenza complications if:
 - They cannot receive influenza vaccine.
 - They have not yet received influenza vaccine this season.
 - They received influenza vaccine in the past 2 weeks or may not have mounted a sufficient response because of immunosuppression (ie, suboptimal immunity).
 - Influenza virus strains circulating in the community are not well-matched with those of the seasonal influenza vaccine.
 - Any unvaccinated child with a family member or close contact who is at high risk for influenza complications and unable to be effectively protected from influenza. Examples include family members or close contacts who are unable to be vaccinated, family members or close contacts who are not anticipated to mount an adequate immune response, and influenza vaccine not well-matched to circulating strains.
8. Postexposure chemoprophylaxis can be considered for known or suspected influenza-exposed family members or close contacts of children at high risk for influenza complications when 1) the family member is likely to have ongoing close contact; AND 2) the at-risk child cannot be otherwise protected from influenza; AND 3) one of the following is true:
 - The exposed family member/close contact is unvaccinated; OR

- The exposed family member/close contact is vaccinated, but the influenza vaccine is not anticipated to provide protection against strains circulating in the community.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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