

Patient name: _____ Date of birth _____ / _____ / _____
 (day) (mo.) (yr.)

Sponsor SSN: _____

Medical Records Location (circle one) : USNH CAPO GAETA

Screening Questionnaire for Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Yes No Don't
Know

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 1. Is the person to be vaccinated sick today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Vaccine	Manufacturer	Lot Number	Exp Date	Dose	Site	Given by
<u>Influenza</u>	_____	_____	_____	_____	_____	_____

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

AHLTA Entry Complete

MRRS Entry Complete

White-Medical Records
Pink-Immunizations/Contingency