

Screening Questionnaire for INFLUENZA Vaccination

For administration of Flu Mist & Injectable influenza Vaccine

The following questions will help us determine if there is any reason we should not give you or your child influenza vaccines today. **PARENTS:** If you are completing this form for your child, please answer for your child. If a question is not clear, please ask for clarification. Thank You!

	YES	NO	Don't Know															
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
2. Is the person to be vaccinated younger than age 2 or older than age 49?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
3. Has the person to be vaccinated ever had an allergic reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
4. Does the person to be vaccinated have any long-term health problems (please circle)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Asthma</td> <td style="width: 33%;">Heart disease</td> <td style="width: 33%;">Seizure disorder</td> </tr> <tr> <td>Allergies</td> <td>Kidney, or Liver disease</td> <td>Cerebral Palsy</td> </tr> <tr> <td>Diabetes</td> <td>Thyroid disorder</td> <td></td> </tr> <tr> <td>Anemia</td> <td>Autoimmune disorder</td> <td></td> </tr> <tr> <td>Cancer</td> <td>Lung disease</td> <td></td> </tr> </table>	Asthma	Heart disease	Seizure disorder	Allergies	Kidney, or Liver disease	Cerebral Palsy	Diabetes	Thyroid disorder		Anemia	Autoimmune disorder		Cancer	Lung disease				
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5. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
6. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
7. Does the person to be vaccinated have an allergy to eggs, foods, latex or Medications, i.e. MSG, arginine, gentamicin, or gelatin. (Check yes if any apply)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
8. Is the person to be vaccinated between the ages of 6 months and 90 years and receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
9. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
10. Has the person to be vaccinated received a vaccine within the last 4-weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
12. Have you read and understand the CDC Vaccine Information Sheet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															

PLEASE PRINT

PATIENT NAME: _____

FIRST
MIDDLE
LAST

STATUS (PLEASE CIRCLE): Active Duty Family Member Retiree DOD Personnel

PATIENT DOB: _____ PATIENT AGE _____

SPONSOR'S/PATIENT COMPLETE SSN: _____ - _____ - _____

SPONSOR'S FULL NAME _____

FIRST
MIDDLE
LAST

Command/ Unit: _____

Who is your Primary Care Manager? _____

Patient/ Guardian Signature: _____ Date: ____/____/____

Form reviewed/vaccine administered by: _____ Vaccine Given: Flu Mist / Influenza Shot

Dosage: _____ Route _____ Site: _____ NAVHOSPCAMLEJNOTE 6230 ENCLOSURE (1) 08/09