Influenza (Flu) Vaccine Screening Questionnaire

Patient name:_____ Date of birth:____ ____ ____
(month) (day) (year)

Screening Questionnaire for Inactivated Injectable Influenza Vaccination (Fluzone, Flulaval, Afluria, Fluarix, Flucelvax)

For adult patients as well as parent 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 an inactivated 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?	☐	☐	☐
2. Does the person being vaccinated have an allergy to **eggs, thimerosal,** neomycin, polymixin, gelatin, formaldehyde, formalin, **beta-propiolactone,** nonyl, or octyl phenol ethoxylate (Triton), sodium taurodeoxylcholate, sodium deoxycholate, polysorbate 80, **cetyltrimethylammonium bromide, Madin Darby Canine Kidney (MDCK)cell protein/DNA,** gentamicin, ovalbumin hydrocortisone, octoxynol-10, α-tocopheryl hydrogen succinate sodium phosphate, calcium chloride, potassium chloride, potassium phosphate, sucrose or latex? *(There is NO latex in multi-dose flu vials.)*	☐	☐	☐
3. Has the person being vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person been vaccinated ever had Guillain-Barre' syndrome?	☐	☐	☐
5. **For California, New York, Missouri, Delaware and Washington ONLY** – Are you pregnant or younger than 3 years old? (younger than 8 years old for Delaware)	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

HALLSVILLE
MEDICAL CLINIC

First Name:		I II III IV V	Age:
Last Name:		Jr. Sr.	
Mailing Address:		Date of Birth:	
City, State:		Phone:	
Zip:		SSN:	
Sex: M F			
Email Address:			

I authorize the release of my information to the following person: (If none, leave blank.)

Emergency Contact Name:	
Emergency Contact Phone:	
Any Restrictions:	
Relationship:	

For office use only.

Procedure: Influenza Vaccine

Date Placed: _____ Site: Left / Right Deltoid

Manufactured By: _____

Lot: _____ Expiration Date: _____

Administered By: _____

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