Patient Name: _____ Date of Birth: _____

Address:_____ Phone #:_____

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 an injectable influenza vaccination today or in the near future. If you answer "yes" to any question, it does not necessarily mean you would not be vaccinated. It only means additional questions must be asked. If a question is not clear, please call Healthvacs at 225-270-2925.

1. Is the person to be vaccinated sick today or had fever in the last 48 hours? Yes No

2. Does the person to be vaccinated have asthma, heart, lung, kidney, liver disease, diabetes, neurologic or neuromuscular disease or a blood disorder? If yes please list. Yes No

3. Is the person to be vaccinated allergic to eggs or ever had a serious reaction to an influenza vaccine in the past? Yes No

4. Has the person to be vaccinated ever had Guillain-Barre' Syndrome? Yes No

Consent for vaccination: _____ Date: _____

For Office Use:

Form reviewed by: _____ Date: _____

Vaccine Admin.: Fluvirin MDV/Fluvirin PFS/Afluria MDV

Influenza Injection Lot# & Exp. Date: _____ Site: LD / RD