Screening Questionnaire for the Influenza Vaccine

Patient name ___________________________________ DOB _________________

The following questions will help us determine which of the influenza vaccine – injectable or nasal – should not be given to your child today and whether a second dose is needed in one month. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional question must be asked. If a question is not clear, please ask you healthcare provider to explain it.

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1. Is the patient between the age of: (check one)
   _____ 0-6 months   _____ 6-35 months   _____ 3-8 years   _____ 9 yrs & over (only answer Q2-13)

	YES	NO
2. Is the patient sick today?	______	______
3. Does the patient have an allergy to eggs or to a component of the influenza vaccine?	______	______
4. Has the patient ever had a serious reaction to influenza vaccine in the past?	______	______
5. Has the patient ever had Guillain-Barre syndrome?	______	______
6. Does the patient have a long-term health problem with heart Disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease or blood disorders?	______	______
7. **If the patient is under 4 years**, in the past 12 months, has a Healthcare provider ever told you that he or she had wheezing or bronchospasms?	______	______
8. Does the patient have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	______	______
9. Is the patient receiving antiviral medication?	______	______
10. Is the patient receiving aspirin therapy or aspirin-containing therapy?	______	______
11. Is the patient pregnant or could she become pregnant within the next month?	______	______
12. Does the patient live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	______	______
13. Has the patient received any other vaccinations in the past 4 weeks?	______	______
14. Did the patient receive any 2009 H1N1 vaccine?	______	______
15. Did the patient EVER received season flu vaccine?	______	______
16. Was last year the patient's 1st year to receive seasonal influenza vaccine?	______	______
17. Did the patient receive 2 doses of seasonal influenza vaccine last year?	______	______

I have received the CDC's Vaccine Information Statement for the Influenza vaccine. I have read or have had explained to me information about the disease and the vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine cited, and ask that the vaccine be given to me or the person named above (for whom I am authorized to make this request).

Form completed by: ____ Date ___________________

Form reviewed by: ____ Date ___________________

9/2010