Screening Questionnaire for Injectable Influenza Vaccination

Patient name: _____ Date of birth: ____/____/____

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.

Dose # 1

	YES	NO	DON'T KNOW
1. Has the patient ever received influenza vaccine before?	☐	☐	☐
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Does the person to be vaccinated have an allergy to egg or to a component of the vaccine?	☐	☐	☐
4. Has the person to be vaccinated ever had a serious reaction to Influenza vaccine in the past?	☐	☐	☐
5. Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐

Parent/ Guardian signature: _____ Relationship to patient: _____ Date: _____

Administered by: _____ Date: _____ Site: _____ Lot #_____Exp: _____

(For clinical staff only-** ☐ **2nd dose required OR** ☐ **2nd dose NOT required **)**

Dose # 2 *(only if indicated per Provider)*

	YES	NO	DON'T KNOW
1. Has the patient ever received influenza vaccine before?	☐	☐	☐
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Does the person to be vaccinated have an allergy to egg or to a component of the vaccine?	☐	☐	☐
4. Has the person to vaccinated ever had a serious reaction to Influenza vaccine in the past?	☐	☐	☐
5. Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐

Parent/ Guardian signature: _____ Relationship to patient: _____ Date: _____

Administered by: _____ Date: _____ Site: _____ Lot #_____Exp: _____

Pediatrics of Bullitt County