

Adults

Patient Name _____ Age _____ Date of Birth _____ / _____ / _____
(mo) (day) (yr.)

Name of relative who is a patient @ Southwest Pediatrics _____

Screening Questionnaire for Injectable Influenza Vaccination

The following questions will help us determine if there is any reason we should not give you or your family the influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you or your family 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person to be vaccinated ever had Guillain-Barré syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is the person to be vaccinated a health care or medical personnel? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. People who live with or care for infants younger than 6 months of age? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. a.) Does the person to be vaccinated have asthma, diabetes, or any other chronic medical conditions? | <input type="checkbox"/> | <input type="checkbox"/> | |
| b.) Are you between 25-64 years of age? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Is the person to be vaccinated pregnant or breastfeeding? | <input type="checkbox"/> | <input type="checkbox"/> | |

Dose _____

Site _____

MA _____

Children

Patient Name _____ Age _____ Date of Birth _____ / _____ / _____
(mo) (day) (yr.)

Name of relative who is patient @ Southwest Pediatrics _____

Screening Questionnaire for Injectable Influenza Vaccination

The following questions will help us determine if there is any reason we should not give you or your family the influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you or your family should not be vaccinated. It just means the additional questions may 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dose _____

Site _____

MA _____