

Date: \_\_\_\_/\_\_\_\_/2007

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Screening Questionnaire for Injectable Influenza Vaccination

The following questions will help us determine if there is any reason we should give your child injectable influenza vaccination. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. Please, ask your provider to explain any questions that are not clear.

Yes      No      Unsure

|  |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|
| Is your child sick today?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Does your child have an allergy to eggs?<br>Egg products or chicken? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Has your child had a reaction to the influenza vaccine in the past?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Has your child ever had Guillain Barre Syndrome?                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Parent/Guardian Signature: \_\_\_\_\_

I give permission for my child to receive the influenza vaccine today and I agree that I have been provided with the Vaccine Information Statement for Influenza Vaccine: \_\_\_\_\_ (initial)

I acknowledge and understand that if my insurance carrier does not cover the cost of this vaccine, I will be responsible for payment: \_\_\_\_\_ (initial)

### Office Use:

Lot # \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ VIS Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Dose:**

0.25

**Location:**

L R Thigh

0.5

L R Deltoid

Staff Initials: \_\_\_\_\_