

## Adult Screening and Immunization Worksheet 2012-2013 Seasonal Influenza Vaccination Program

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<b>Name (Please Print):</b>	<b>Date of Birth:</b>	<b>Sponsor's SSN:</b>
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### Circle answers to questions 1-11:

1	Do you currently feel sick or have a fever?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2	Have you ever had a serious reaction to a flu vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3	Do you have a history of Guillain-Barre Syndrome (GBS)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4	Do you have an allergy to any of the following: eggs, egg protein, MSG, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde, latex or other vaccine components?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5	Are you pregnant or planning to become pregnant in the next month?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6	Are you 50 years of age or older? <b>(If marked Yes, skip questions 7-11)</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7	Do you have a chronic health problem such as: asthma, heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes) or a blood disorder?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
8	Do you have a weakened immune system because of HIV or another disease that affects the immune system, long-term high-dose steroid treatments, or cancer treatment with radiation or drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
9	Are you taking any prescription medicines to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
10	Do you live with or have close contact with severely immunocompromised individuals or someone who must be in a protective environment (such as transplant recipients?)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
11	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks? (particularly live vaccines)	<input type="checkbox"/> No	<input type="checkbox"/> Yes

\*\*\*\*Please scan your CAC card for electronic entry of your vaccination, if process is in place.\*\*\*\*

*"I have read or have had explained to me the information in the 2012-2013 Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine."*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Below to be completed by healthcare staff

<input type="checkbox"/> Give injectable flu vaccine today <input type="checkbox"/> Give intranasal flu vaccine today <input type="checkbox"/> Do not administer flu vaccine today	<b>Vaccine Information Statement provided (check box)</b> <input type="checkbox"/> Inactivated Influenza Vaccine (TIV) <input type="checkbox"/> Live, Attenuated Influenza Vaccine (LAIV)		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">Interviewer's Signature</td> <td style="width: 40%; border: none;">Date</td> </tr> </table>	Interviewer's Signature	Date
Interviewer's Signature	Date		

### Vaccine Administered

<input type="checkbox"/> <b>Live Intranasal Influenza</b> (FluMist, MedImmune) (INI) Lot # _____ Dose: 0.2 ml      Route: Intranasal	<input type="checkbox"/> <b>Inactivated Influenza</b> (Fluzone, Sanofi-Pasteur) (INJ) <input type="checkbox"/> <b>Inactivated Influenza</b> (Afluria, CSL, preservative-free) (INP) <input type="checkbox"/> Lot # _____ Left / Right Deltoid Dose: 0.5 ml      Route: IM
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**Comments:**

<b>Administered by:</b>	<b>Date</b>
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