# 2015-2016 ADULT SEASONAL INFLUENZA VACCINATION PROGRAM

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| 1 | Name (Please Print) | Date of Birth | Sponsor's Full SSN |
|---|---|---|---|
| | _____, _____, _____<br>Last First MI | _____, _____, _____<br>DD MMM YYYY | __ __ __ - __ __ - __ __ __ __ |

| 2 | ADULT SCREENING AND IMMUNIZATION WORKSHEET<br>18 Years and Older | | |
|---|---|---|---|
| 1 | Do you currently feel sick or have a fever? | ☐ NO | ☐ YES |
| 2 | Have you ever had a serious reaction to a flu vaccine? | ☐ NO | ☐ YES |
| 3 | Do you have a history of Guillain-Barre Syndrome (GBS)? | ☐ NO | ☐ 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. | ☐ NO | ☐ YES |
| 5 | Are you pregnant or planning to become pregnant in the next month? | ☐ NO | ☐ YES |
| 6 | Are you 50 years of age or older? ***(If marked Yes, skip questions 7-11)*** | ☐ NO | ☐ 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? | ☐ NO | ☐ 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? | ☐ NO | ☐ YES |
| 9 | Are you taking any prescription medicines to prevent or treat influenza? Have you taken any antivirals in the last 48 hours? | ☐ NO | ☐ 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?) | ☐ NO | ☐ 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) | ☐ NO | ☐ YES |
| *** | **I have been offered an Influenza Vaccine Information Statement (VIS).** | ☐ NO | ☐ YES |

*********STOP HERE*********

***TO BE COMPLETED BY HEALTHCARE STAFF*** DATE: _____

☐ **GIVE INTRANASAL**

☐ FluMist, MedImmune

**Lot#**_____

**Dose:** 0.1 ml each nostril

**Route:** Intranasal

☐ **GIVE INJECTABLE**

☐ **FLULAVAL**

☐ **FLUVIRIN**

☐ **AFLURIA**

**Lot#**_____

**Dose:** 0.5 ml

Route: IM Right / Left Deltoid

| SCREENED BY: | ADMINISTERED BY: |
|---|---|
| | |

***THIS FORM WILL BE DESTROYED upon completion of electronic entry (AHLTA, MEDPROS, etc.)**