2015-2016 ADULT SEASONAL INFLUENZA VACCINATION SCREENING WORKSHEET
18 YEARS AND OLDER

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***Please complete Sections A and B ***

A

Name(Please Print): _____ ***Patient's DOB:*** _____
LAST FIRST MI (DD-MMM-YYYY)

Sponsor's full SSN with FMP: _____-_____-_____-_____ ***Patient's DOD ID Number:*** _____
FMP FULL SPONSOR'S SSN (# BEHIND ID/CAC CARD)

B **Check box to answer questions 1-12 below**

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	Have you had any food or medication reactions?	☐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, neurologic or neuromuscular disease, liver 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; take long-term high-dose steroid treatments, or cancer treatment with radiation or medications?	☐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 expect to have close contact with someone who has a severely weakened immune system who must be in a protective environment (e.g. in isolation?)	☐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 – Varicella, MMR, Yellow Fever, Smallpox)?	☐No	☐Yes

"I have read or have had explained to me the information in the 2015-2016 Influenza Vaccine Information Statements (VIS) for Live, Intranasal Influenza or Inactivated Influenza. 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 vacine." ☐Yes

***** STOP ******** BELOW THIS LINE IS TO BE COMPLETED BY HEALTH CARE STAFF ******** STOP*****

☐ **Give injectable flu vaccine today** ☐ **Give intranasal flu vaccine today** ☐ **Do not administer flu vaccine today**

Vaccine administered today

☐ **Live Intranasal Influenza** – FluMist, MedImmune
Lot # _____
Place sticker here:
Dose: 0.2 ml (0.1 ml each nostril)
Route: Intranasal

Inactivated Injectable Influenza
☐ Fluarix, Glasko Smith Kline (GSK)
☐ Afluria, CSL
Lot # _____ **Place sticker here:**
Dose: 0.5mL
Route: IM Deltoid LEFT / RIGHT

Screened by (Print full name):	**Administered by (Print full name):**	**Today's date (Date Vaccine was administered):**

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