2015-2016 PEDIATRIC / ADOLESCENT SEASONAL INFLUENZA VACCINATION SCREENING WORKSHEET FROM 6 MONTHS – 18 YEARS OF AGE

The following questions will help us determine if we should give your child the intranasal or the injectable influenza vaccination today. If you answer "yes" to any question, we will ask additional questions to determine which vaccine, if any, your child will receive. Please speak to your healthcare provider, if you have any questions.

A **Check box to answer questions 1-14 below**

1	How many doses of seasonal flu vaccine has your child received in their lifetime?	☐0 ☐1	☐2 or more
2	Does your child currently feel sick or have a fever?	☐No	☐Yes
3	Has your child ever had a serious reaction to a flu vaccine in the past?	☐No	☐Yes
4	Does your child have a history of Guillain-Barre Syndrome (GBS)?	☐No	☐Yes
5	Has your child had any food or medication reactions?	☐No	☐Yes
6	Is your child younger than 2 years of age?	☐No	☐Yes
7	Does your child have a history of asthma, reactive airway disease, or wheezing?	☐No	☐Yes
8	Does your child have heart disease, lung disease, kidney disease, liver disease, neurological or neuromuscular disease, cardiovascular disease, metabolic disorders (e.g., diabetes), a blood disorder or any other chronic health conditions?	☐No	☐Yes
9	Does your child 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
10	Is your child taking aspirin or aspirin-containing products?	☐No	☐Yes
11	Is your child taking any prescription medicines to prevent or treat influenza? Have they taken any antivirals in the last 48 hours?	☐No	☐Yes
12	Does your child live with or expect to have close contact with individuals with a severely weakened immune system who must be in a protective environment (those in isolation?)	☐No	☐Yes
13	Is the adolescent to be vaccinated pregnant?	☐No	☐Yes
14	Has your child received any vaccines within the last 30 days or are they going to receive any additional vaccines within the next 4 weeks?	☐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 askquestions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vacine." ☐Yes

B ******Please complete demographics below ***** *otherwise to be completed by healthcare staff*

Child's Name(Please Print): _____ ***Child's DOB:*** _____ ***(DD/MMM/YYYY)***

Sponsor's full SSN with FMP: _____-_____-_____-_____ ***Patient's DOD ID Number:*** _____

Parent/Guardian/Adolescent Signature: _____ **Child's Age:** _____

***** 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 – 2 to 49 yrs (FluMist, MedImmune)

Lot # _____ **Place sticker here:**

Dose: 0.2 ml (0.1 ml each nostril) **Route**: Intranasal

☐ Inactivated Influenza – 6 – 35 mos (Fluzone peds, Sanofi Pasteur)

☐ Inactivated Influenza – 3 yrs and older (Fluarix, GSK)

☐ Inactivated Influenza – 9 yrs and older (Afluria, CSL)

Lot # _____ **Place sticker here:**

Injectable description – continued

Dose: (6-35 mo): 0.25mL

Route: IM (6-12mo) Thigh L / R

IM (>12mo) Deltoid L / R

Dose: (≥36mo): 0.5mL

Route: IM Deltoid L / R

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.)**