# Screening Questionnaire for Influenza Vaccination

| Clinic Use Only: |
| --- |
| _____Use **VFC** |

**For adult patients as well as parents of children to be vaccinated:** The following questions will help us determine if there is any reason we should not give you or your child the influenza vaccine today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't Know |
| --- | --- | --- | --- |
| 1. Does the person to be vaccinated have a fever today? | ☐ | ☐ | ☐ |
| 2. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? (Severe allergic reaction / anaphylaxis) | ☐ | ☐ | ☐ |
| 3. Has the person to be vaccinated ever had Guillain-Barré syndrome within 6 weeks after previous influenza vaccine? | ☐ | ☐ | ☐ |
| **(Flu Mist)** | | | |
| 4. Does the person to be vaccinated has a history of asthma or wheezing? | ☐ | ☐ | ☐ |
| 5. Is the person being vaccinated immunocompromised? | ☐ | ☐ | ☐ |
| 6. Is the person being vaccinated receiving aspirin or any salicylate containing medications? | ☐ | ☐ | ☐ |

I give the consent for the influenza vaccination to be administered to:

| **PATIENT'S FIRST AND LAST NAME** | **DATE OF BIRTH** |
| --- | --- |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |

I have read and completed the above Vaccine Information Statement for the flu vaccine. I know the benefits and the risks of the vaccine. I have had a chance to ask questions about the disease, the vaccine and how the vaccine is given. I know that the person receiving the vaccine will have the vaccine put into his or her body to prevent an infectious disease.

_____ _____/_____/_____

**Signature of Parent or Guardian** **Date**