ADULT - SCREENING QUESTIONNARIE AND AUTHORIZATION FOR INFLUENZA VACCINE

PATIENT NAME: _____ **DOB:** _____

The following questions will help us determine whether you can receive the influenza vaccine today.
If you answer "Yes" to any questions it does not necessarily mean that you cannot receive the vaccine.
It just means that we may need to ask additional questions.

	Yes	No	Don't Know
1 Which influenza vaccine are you requesting? **Flu Shot** ☐ **FluMist (nasal vaccine)** ☐			
2. Are you sick today?	☐	☐	☐
3. Have you had a fever within the last 48 hours?	☐	☐	☐
4. Have you had a reaction to the Influenza vaccine or any other vaccine in the past? If "Yes" which one?	☐	☐	☐
5. Are you allergic to eggs, egg products, gelatin, gentamicin or arginine?	☐	☐	☐
6. **Females only -** Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
7. Do you have a prior history of Gullian-Barre Syndrome (GBS)?	☐	☐	☐
8. Do you have a chronic condition or long-term health problem? **If yes, check all that apply.** ☐Asthma ☐Diabetes ☐Heart Disease ☐Kidney Disease ☐Liver Disease ☐Lung Disease ☐Other _____	☐	☐	☐
9. Have you received any vaccinations in the last month? If "Yes" - Which ones?	☐	☐	☐
10. **For FluMist only -** Do you have a history of asthma or wheezing?	☐	☐	☐
11. **For FluMist only -** Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	☐	☐	☐
12. **For FluMist only** - Are you taking aspirin, Tamiflu, amantadine or rimantadine?	☐	☐	☐

Form completed by (patient or representative): Date:

Form reviewed by: Date:

If you choose to be immunized with the Influenza Virus Vaccine, please read the following information and sign below.

1. I agree to receive the Influenza Virus Vaccine.
2. The CDC Vaccine Information Statement has been provided to me with all the necessary information so I can make an informed decision.
3. I understand the risks of the Influenza Virus Vaccine.
4. I understand that the Influenza Virus Vaccine is highly recommended for anyone with the following health conditions: heart disease, lung disease, asthma, kidney disease, metabolic diseases (such as diabetes) and persons over the age of 6 months.
5. I have been provided the opportunity to ask questions about the disease, the vaccine, and how the vaccine is to be administered.
6. I know that I will have the vaccine injected into my body to help prevent the influenza virus.
7. I am a competent adult and am freely providing my consent for this vaccine to be administered.
8. **Payment:** I understand that I am responsible for payment in full for this service and that payment is due at the time of service.

By signing below you authorize Austin Children's Clinic, PA to administer the Influenza Virus Vaccine to the above named child. You also agree to pay any unpaid charges for this vaccine.

Patient Signature: Date:

STAFF USE ONLY			Temperature		
Family Account #			Manufacturer & Lot		
VIS Date			Administration Site		