Put ID sticker HERE

Screening Questionnaire for Influenza Vaccination

(Please fill out form for each person receiving a vaccination today)

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 live attenuated INTRANASAL influenza vaccine (FluMist) 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 the Clinic Staff Member to explain it.

Name (please print) _____ Zip Code _____ **Age:** _____ ☐ Female ☐ Male (please check one)

I heard about this vaccination clinic from: ☐ Internet ☐ Newspaper ☐ Bus Ad ☐ Flyer ☐ Other: _____

Please answer the following questions. Check NO or YES:

1. Is the person to be vaccinated sick today?	☒ No ☐ Yes
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☒ No ☐ Yes
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	☒ No ☐ Yes
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☒ No ☐ Yes
5. Is the person to be vaccinated pregnant or could she become pregnant with the next month?	☒ No ☐ Yes
6. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or other blood disorders?	☐ No ☐ Yes
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids or cancer treatment with radiation or drugs?	☐ No ☐ Yes
8. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective isolation (e.g. an isolation room of a bone marrow transplant unit)?	☐ No ☐ Yes
9. If the person to be vaccinated is age 2 to 4 years, have you been told in the past 12 months that your child had wheezing or asthma?	☐ No ☐ Yes
10. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐ No ☐ Yes
11. Has the person to be vaccinated received any other vaccination in the past 4 weeks?	☐ No ☐ Yes
12. Is the person to be vaccinated receiving antiviral medications?	☐ No ☐ Yes

***FOR CLINIC STAFF ONLY*:**

Vaccine Type ☒ Injectable (SHOT) ☐ Intranasal (MIST)	**LEFT** **RIGHT** **NASAL** Vaccinator (Initials): _____	Place all Lot # Stickers HERE

Griage – give VIS & screening form TIME IN: _____

Screener – Review medical history TIME IN: _____

Vaccinator – vaccinate client TIME IN: _____

Paperwork Collection – Collect screening form TIME IN: _____