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## 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	<b>Age:</b> <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> Female <input type="checkbox"/> Male (please check one)
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I heard about this vaccination clinic from:  Internet     Newspaper     Bus Ad     Flyer     Other: \_\_\_\_\_

**Please answer the following questions. Check NO or YES:**

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|--|---|
| 1. Is the person to be vaccinated sick today?  | <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?  | <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?  | <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. Has the person to be vaccinated ever had Guillain-Barré syndrome?   | <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 5. Is the person to be vaccinated pregnant or could she become pregnant with the next month?   | <input checked="" type="checkbox"/> No <input type="checkbox"/> 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? | <input checked="" type="checkbox"/> No <input type="checkbox"/> 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?        | <input checked="" type="checkbox"/> No <input type="checkbox"/> 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)?           | <input checked="" type="checkbox"/> No <input type="checkbox"/> 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?  | <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 10. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?   | <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 11. Has the person to be vaccinated received any other vaccination in the past 4 weeks?  | <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes |
| 12. Is the person to be vaccinated receiving antiviral medications?  | <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes |

**FOR CLINIC STAFF ONLY:**

Vaccine Type <input checked="" type="checkbox"/> Injectable (SHOT) <input type="checkbox"/> Intranasal (MIST)	<b>LEFT                      RIGHT</b>  <b>NASAL</b>  Vaccinator (Initials): _____	Place all Lot # Stickers HERE
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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: