



Influenza Vaccine Screening & Consent Form

Patient Information Form

Last Name: _____ First Name: _____ Middle Name: _____

Address/City/State/Zip: _____

Phone Number: _____

Mother's Maiden Last Name (if child): _____ Mother's First Name (if child): _____

Patient Social Security Number (optional): _____ Gender: Female, Male

Date of Birth: _____ Country of Birth: _____ County of Residence: _____

Ethnicity: Hispanic or Latino, Not Hispanic or Latino

Race: American Indian, Alaska Native, Asian, White, Other,

Native Hawaiian or other Pacific Islander, Black or African American

Doctor: _____ School: _____

Insurance Eligibility: Not determined/unknown, Insured, vaccine covered, Medicaid,
 Uninsured, Medicare, American Indian/Alaska Native, Underinsured

Insurance Provider: _____ Medicare Number: _____

Responsible Party Information (if child or different from above)

Last Name: _____ First Name: _____ Middle Name: _____

Relation: _____ Phone Number: _____

Address/City/State/Zip: _____

For All Types of Influenza Vaccine

Yes No

1. Does the person to be vaccinated have an allergy to eggs, gelatin, or gentamicin?

2. Does the person to be vaccinated have any other serious allergies that you know of?
Please List: _____

3. Has this person had a serious reaction to the influenza vaccine in the past?

4. Has this person ever had Guillain-Barre syndrome?

Signature of Consent: _____ Date: _____

Questions for Flumist Recipient Only

Yes No

- 5. Is this person younger than 2 years of age? Yes No
- 6. Is this person a child age 2 through 4 years with a history of recurrent wheezing? Yes No
- 7. Does this person have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease, anemia or blood disorders? Yes No
- 8. Does this person have a weakened immune system because of disease or treatment with drugs such as steroids, cancer treatment or x-rays? Yes No
- 9. Is this person receiving aspirin therapy? Yes No
- 10. Is this person pregnant? Yes No
- 11. Does this person expect to have close contact with a person whose immune system is severely compromised and must be in a protective environment (such as a hospital room with reverse air flow?) Yes No
- 12. Has this person received any other vaccines in the past 30 days? Yes No

Signature of Consent: _____ Date: _____

Office Use:

Please Check All that Apply:

- Pregnant Woman
- Household Contact/Caregiver of child less than 6 months
- Healthcare/EMS
- Child 6 months through 24 years
- Person 25 – 64 years with high risk of medical complications
- Healthy person aged 25-64 years
- Person 65 years or older

Date of Vaccination: _____ Vaccine Trade Name: _____

Vaccine Lot #: _____ Vaccination Clinic Site: _____

Nurse: _____

Route: IM Intranasal

Doses: 1st dose 2nd dose