

Screening Checklist for Influenza Vaccination

For use with people age 2 through 18 years: The following questions will help us determine if there is any reason we should not give you or your child influenza vaccine. 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. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than age 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. 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), or anemia or another blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or in the past 3 months, have they taken medication that weakens the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated receiving antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. 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 protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form Completed by: _____ Date: _____ / _____ / _____
 (month) (day) (year)

Form Reviewed by: _____ Date: _____ / _____ / _____
 (month) (day) (year)

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date <u>1st Dose</u> Administered	Date <u>2nd Dose</u> Administered	Route/Site		Staff Signature	Vaccine Manufacturer	Lot Number/ Exp Date
			1st Dose	2nd Dose			
Injectable Influenza			IM <input type="checkbox"/> R <input type="checkbox"/> L	IM <input type="checkbox"/> R <input type="checkbox"/> L		Sanofi	
			<input type="checkbox"/> Arm <input type="checkbox"/> Leg	<input type="checkbox"/> Arm <input type="checkbox"/> Leg		----- GSK	

<u>Vaccine</u>	<u>Description</u>	✓
90685	Flu vaccine, quadrivalent split virus, preservat, .25 for 6 mos - 35 mos	
90686	Flu vaccine, no prsv 4 val .5ml for 3yrs and older	
90688	Flu vaccine, 4 val multidose vial for ages 6 mos. and older	