

Clinic Name: _____ City: _____

Please answer the following questions. Your provider or support staff will discuss vaccination recommendations with you.

Please state the age of the person to be vaccinated today _____	
Is the person to be vaccinated pregnant or could she become pregnant within the next month?	Y – N
Is the person to be vaccinated allergic to eggs or other parts of the vaccine?	Y – N
Has the person to be vaccinated ever had a reaction to a flu shot or FluMist?	Y – N
Is the person to be vaccinated feeling ill today? (fever, nasal congestion)	Y – N
Does the person to be vaccinated have a long term health condition such as diabetes, kidney or liver disease, heart or lung disease, anemia or other blood disorder, or nervous or muscle systems?	Y – N
Does the person to be vaccinated have a muscle or nerve disorder (such as cerebral palsy) that can lead to breathing or swallowing problems?	Y – N
Does the person to be vaccinated have a weakened immune system because of infection or disease that affects the immune system (such as HIV/AIDS, long term treatment with drugs such as high-dose steroids, cancer treatment with radiation or drugs, etc.)	Y – N
Does the person to be vaccinated have asthma? (or is this person a child younger than 5 with asthma or had one or more episodes of wheezing within the past year?)	Y – N
Is the person to be vaccinated between 2 and 17 years of age and receiving aspirin therapy?	Y – N
Has the person to be vaccinated had Guillain-Barre Syndrome?	Y – N
Does the person to be vaccinated live with or care for an individual(s) who requires a protective environment? (i.e. bone marrow transplant or stem cell transplant patients)	Y – N
Has the person to be vaccinated received any other vaccinations in the last 4 wks?	Y – N
Have you taken any antiviral medication (eg. Tamiflu, Relenza) in the last 48 hours?"	Y – N

Please list any other allergies _____

PERSON RECEIVING VACCINE (please print)	I have been given a copy and have read or have had explained to me information about influenza vaccine. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that it be given to me or the person named below for whom I am authorized to make this request.
--	--

Last Name First Name MI	Birthdate
-------------------------	-----------

Address City State Zip Phone # _____

Signature of person to receive vaccine or person authorized to make request _____

Today's vaccination is the patient's: 1st dose or 2nd dose

Which priority group does the patient fall in to? (check all that apply)

Pregnant Healthcare/Emergency Medical Service Worker

Contact of infant < 6 months of age Healthy child 5 yrs through 18yrs of age

Child 6 months to 4 yrs Youth 19yrs through 24yrs of age

Child 5 yrs to 18 yrs of age with high risk conditions Adults 25 though 64yrs of age with a high risk condition

Once the other priority groups are covered and permission is given from the state or federal agencies immunizations may be given to:

All adults 25 to 64 yrs of age Adults 65+ yrs old

	Type	Date/Time	Vaccine Manufacturer	Vaccine Lot Number	Expiration Date	Route	Site	Signature Of Person Administering Vaccination
H1N1 Influenza Vaccine	LAIV		Medimmune			NAS		
			Sanofi Pasteur					
	TIV		Novartis			IM	L R	
			GlaxoSmithKline				DELTOID	
			CSL				THIGH	