2015-2016 SEASONAL INFLUENZA SCREENING QUESTIONAIRE

Patient Name:_____ DOB:_____

Patient temperature:_____

The following questionnaire will help us to know if you or your child can get the seasonal influenza vaccine. Please mark "YES" or "NO" for each question.

A.) If you answer "NO" to all four of these questions, you or your child can probably get the vaccine. If you answered "YES" to any, it does not necessarily mean you of your child cannot be vaccinated. It just means that additional questions must be asked.

1) Does the person to be vaccinated have a serious allergy to eggs? YES___ NO___

2) Does the person to be vaccinated have any other serious allergies? YES___ NO___

3) Has the person to be vaccinated ever had a serious reaction to a previous dose of flu vaccine? YES___ NO___

4) Has the person to be vaccinated ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after Receiving a flu vaccine? YES___ NO___

PATIENT/GUARDIAN SIGNATURE:_____DATE:_____

FORM REVIEWED
BY:_____

VACCINE:_____LOT:_____ EXP.
DATE:_____