

# 2013-2014 Adult Influenza Screening Questionnaire

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<b>Recipient's Name:</b> (Print legibly the last and first name)	<b>Date of Birth:</b> (month/day/year)	<b>Sponsor's SSN:</b>
<b>Sponsor's Service:</b> Army Air Force Navy/Marine Corps	<b>Recipient's Status:</b> Active Duty Reserve/NG Dependent Civilian Retired	

1.	Do you feel sick or have fever today?	No	Yes
2.	Have you ever had a serious reaction to a flu vaccine?	No	Yes
3.	Do you have a history of Guillain-Barré Syndrome (GBS)?	No	Yes
4.	Do you have an allergy to eggs, egg protein, MSG, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde, latex, or other vaccine components?	No	Yes
5.	Are you pregnant or planning on become pregnant in the next month?	No	Yes
6.	Is the patient <b>50 years or older?</b> (If yes, skip to question # 11)	No	Yes
7.	Do you have a chronic health problem such as: <i>asthma, heart disease, lung disease, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes) or a blood disorder?</i>	No	Yes
8.	Do you have a weakened immune system because of HIV or another disease that affects the immune system; long-term high dose steroid treatments, or cancer treatment with radiation or drugs?	No	Yes
9.	Are you taking any prescription medicines to prevent influenza? Have you taken any antivirals taken in the last 48 hours?	No	Yes
10.	Do you live with, or expect to have close contact with, severely immunocompromised individuals living in a protective environment (e.g., in isolation)?	No	Yes
11.	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next 4 weeks?	No	Yes

I have read, or have had explained to me, the information in the 2013-2014 Influenza Vaccine Information Sheet (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.  
(This form is subject to the Privacy Act of 1974)

Recipient's signature \_\_\_\_\_ Date \_\_\_\_\_

### Below to be completed by health care provider only

<input type="checkbox"/> Give injectable flu vaccine today	<input type="checkbox"/>	Comments:
<input type="checkbox"/> Give intranasal flu vaccine today	Medication Reconciliation	Interviewer's Signature: _____
<input type="checkbox"/> Do NOT administer flu vaccine today		

### Vaccine Administered

<input type="checkbox"/> Live Intranasal <b>Flumist</b> (Adult)	<input type="checkbox"/> Inactivated Influenza <b>Fluzone Shot</b> (Pre-school / Adult)	<input type="checkbox"/> Inactivated Influenza <b>Fluce/vax Shot</b> (4d-It)	<input type="checkbox"/> Inactivated Influenza <b>Fluvirin Shot</b> (Pre-school / Adult)	<input type="checkbox"/> Inactivated Influenza <b>Afluria Shot</b> (Adult)
<u>Ages:</u> 2yrs -- 49yrs	<u>Ages:</u> 26 months & older	<u>Ages:</u> 18 yrs & older	<u>Ages:</u> 4 yrs & older	<u>Ages:</u> 9 yrs and older
<u>Dose:</u> 0.2ml	<u>Dose:</u> 0.5ml	<u>Dose:</u> 0.5ml	<u>Dose:</u> 0.5ml	<u>Dose:</u> 0.5ml
<u>Route:</u> Intranasal	<u>Route:</u> IM L / P Deltoid	<u>Route:</u> IM L / R Deltoid	<u>Route:</u> IM L / R Deltoid	<u>Route:</u> IM L / R Deltoid
<u>Lot #</u> _____	<u>Lot #</u> _____	<u>Lot #</u> _____	<u>Lot #</u> _____	<u>Lot #</u> _____

Administered by: \_\_\_\_\_ Date: \_\_\_\_\_