

Patient Name: _____ Date of Birth: ____/____/____
 Phone Number: _____ (mm) (dd) (yr)
 Address: _____ City, State, Zip _____
 Patient SSN# /Medicare Number/Insurance ID : _____

**Screening Questionnaire for
Inactivated Injectable Influenza Vaccination**

For adult patients to be vaccinated:

The following questions will help us determine if there is any reason we should not give you inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you 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.

- 1. Is the person to be vaccinated sick today? YES NO
- 2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? YES NO
- 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? YES NO
- 4. Has the person to be vaccinated ever had Guillain-Barré syndrome? YES NO

Patient or POA Signature : _____ Date: _____

**To be completed by Pharmacist
Influenza Vaccine**

Administration Date _____

Administration Site Left Arm Right Arm

Dosage 0.5ml 2.5ml LAIV

Manufacturer & Lot Number _____

VIS Date _____

Pharmacist's Signature: _____ Date: _____