PATIENT NAME_____

DATE OF BIRTH_____/_____/_____
MONTH DAY YEAR

□ SMH EMPLOYEE □ SMH VOLUNTEER □ OTHER

[ ] Speare Primary Care_____ [ ] Mid-State _____

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For Patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. 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 health care provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have a severe allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Have you ever had a serious reaction to the influenza vaccine in the past?	☐	☐	☐
5. Have you ever had Guillain-Barre syndrome?	☐	☐	☐
6. Are you currently taking any blood thinners?	☐	☐	☐

I have read and understand the Vaccine Information Sheet and wish to have the vaccine administered.

Signature_____ Date_____

✓ **Influenza VIS sheet given: 8/6/21** **VIS Sheet Date**

✓ **Influenza vaccine**

Lot #: _____

Exp. Date:_____

Site given: _____

Form Reviewed and Vaccine Administered by:

Signature_____ Date/Time_____