

Screening Questionnaire for Injectable Influenza Vaccination 2016

For office use only
 City Employee
 MJSD Employee
 Wellness
 Resident/17.00

Information about person to receive vaccine. (Please Print)				
Name: Last	First	Middle Initial	Birthdate	Age
Address: Street	City	County	State	Zip

- | | Yes | No | Don't Know |
|--|--------------------------|--------------------------|--------------------------|
| 1. Is the person to be vaccinated sick today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had Guillain-Barré syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below from whom I am authorized to make this request.

Form completed by: _____ **Date:** _____

Form reviewed by: _____ **Date:** _____

+++++ **For Health Department Use** +++++

Date Vaccine Administered 10 - -2016

Vaccine Manufacturer: Fluarix - Quad

Vaccine Lot Number: 79PE5 (VIS 8-15-15)

Site of Injection: LD RD

Signature of Vaccine Administrator: _____