Adult Screening and Immunization Documentation Form
Seasonal Influenza Vaccination Program

LAST NAME:_____ **First Name:** _____

Circle Answers to Questions 1- 11

1.	Do you currently feel sick or have a fever?	Yes	No
2.	Have you ever had a serious reaction to a flu vaccine (such as hives or anaphylaxis)?	Yes	No
3.	Do you have a history of Guillian-Barre Syndrome (GBS) within 6 weeks of prior influenza vaccination?	Yes	No
4.	Do you have an allergy to any to the following: eggs, egg protein, MSG, gentamicin, gelatin, arginine, neomycin, polymyxin B, formaldehyde, latex, or other vaccine components?	Yes	No
5.	Are you pregnant, breastfeeding, or planning on becoming pregnant in the next 30 days?	Yes	No
6.	Have you had any vaccines within the last 30 days or plan to receive any vaccines in the next 4 weeks? If so please list: _____	Yes	No
7.	Are you over 50 years of age?	Yes	No
8.	Do you have a chronic health problem such as: Asthma, Lung Disease, Heart Disease, Kidney Disease, Metabolic Disease (e.g. diabetes), or a blood disorder?	Yes	No
9.	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 treatments with radiation drugs?	Yes	No
10.	Are you taking **PRESCRIPTION** medications to prevent or treat influenza? Have you taken any anti-virals within the last 48 hours?	Yes	No
11.	Do you live with or have close contact with ***severely*** immune-compromised individuals or someone who must be in a protective environment (such as transplant recipients)?	Yes	No

"I have received the Vaccine Information Sheet (VIS) I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine"

Patient Signature:_____Date:_____

Interviewer's Signature:_____Date:_____

Below to be completed by healthcare staff

Influenza Vaccine: _____Fluzone Intradermal _____Fluzone Intradermal (High Dose)

Place Label Here: Lot # _____ Dose: 0.5ml Route: ID Deltoid Left / Right

ADMINISTERED BY: (PRINT Name and Title) SIGNATURE: DATE (YYYYMMDD)

_____ _____ _____

TO BE COMPLETED BY ALL ACTIVE DUTY MILITARY

UIC:_____ UNIT: _____

PHONE NUMBER: _____