



INFLUENZA IMMUNIZATION SCREENING FORM

*Please complete & sign this page & hand to the nurse at the time of vaccination
The CDC Vaccine Information Statement is for your records.*

The following questions will help us determine if the flu vaccine may be given today.
If a question is not clear, please ask the nurse to explain it.

Please check “yes” or “no” for the following questions: If “yes”, please discuss with nurse.

If “yes” is applicable, the flu vaccine may <i>not</i> be advised.	Yes	No
Are you allergic to eggs or egg products or chicken proteins?		
Are you allergic to latex?		
Are you allergic to thimerosal?		
Have you had Guillain-Barre syndrome? (a serious neurological disease)		
Have you had a bad reaction to any vaccines including the flu vaccine		
Are you moderately or severely ill? i.e. do you have a fever? (Fever over 101°F)		
For Women: Are you pregnant or breast-feeding? If yes, please let the nurse know		
For Women: Have you had a mastectomy? If yes, please let the nurse know		

If you have any questions, please ask the nurse or check with your physician before receiving the vaccine.

I have read the CDC Vaccine Information Sheet about Influenza and Influenza vaccine, and I have had a chance to ask questions. I understand the benefits and risks of Influenza vaccination and request that the vaccine is given to me.

Information-Person to Receive Vaccine

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City & Zip _____

Daytime Phone #: _____ Signature: _____

Circle One: Male Female Email address: _____

For Clinic Use Only:

Clinic Site: _____ Preservative Free Dose ____yes ____no

Date of Vaccination: _____ Manufacturer & Lot #: _____

Site: IM Right _____ Left _____ Administered By: _____