Adult 2011-2012 Seasonal Influenza Vaccination Form

PRIVACY ACT STATEMENT: This form contains sensitive Personally Identifiable Information (PII), protected under the Privacy Act which is FOR OFFICIAL USE ONLY and must be protected in accordance with the Privacy Act, 5 USC § 552a. Unauthorized disclosure or misuse of the sensitive PII may result in criminal and/or civil penalties.

PLEASE PRINT LEGIBLY

Patient's full name:_____ Patient's SSN:_____ Patient's birth date:_____

Sponsor's full name:_____ Sponsor's SSN:_____ Sponsor's birth date:_____

Other Health Insurance Company: _____ E-mail address (for survey):_____

FOR CIVILIAN EMPLOYEES/SOLDIERS	**Circle one / all that apply:**
Job title: _____ Organization:_____	DA Civilian Retiree Soldier Other

Your answers to the questions below help us determine if there is a reason we should not vaccinate you against influenza. A "YES" answer to a question does not necessarily mean you should not be vaccinated. It may mean that we must ask more questions. Please ask the healthcare provider to explain any question you do not fully understand.

1	Have you ever received the seasonal flu vaccine?		YES	NO
2	Have you ever had a serious reaction to any vaccine?		YES	NO
3	Do you have an allergy to eggs, egg protein, monosodium glutamate (MSG), gentamicin, neomycin, polymyxin, gelatin, arginine, thimerosol, formaldehyde, latex, or other vaccine components?		YES	NO
4	Do you have a history of Guillain-Barre syndrome (GBS)?		YES	NO
5	Are you sick with a fever today?		YES	NO
6	Are you pregnant or planning to become pregnant in the next month?	NA	NO	YES
7	Do you have a history of asthma, reactive airway disease or wheezing?		YES	NO
8	Do you smoke?		YES	NO
9	Do you have a history of: heart, lung, kidney, metabolic (diabetes for example), or blood disease, or ANY other life-long health condition?		YES	NO
10	Do you have a weakened immune system, take long-term high-dose steroid treatment, or take cancer treatments?		YES	NO
11	Are you currently taking any prescription medications to prevent or treat the flu?		YES	NO
12	Have you taken any prescription medications to prevent or treat the flu in the last 48 hours?		YES	NO
13	Will you have close contact with a severely immunocompromised person (ex: someone who must in a protective environment)?		YES	NO
14	Do live with or take care of children who are younger than 5 years old or adults who are older than 50?		YES	NO
15	Are you a healthcare provider?		YES	NO
16	Have you received any vaccine within the last 30 days or are you going to receive any other vaccine within the next 4 weeks?		YES	NO
17	Please list all the medications you currently take: (for medication reconciliation).			

CONSENT FOR VACCINATION: My signature below means that I give consent to be vaccinated. I have read, had access to, or had explained to me the information contained in the 2011-2012 Influenza Vaccine Information Sheet. I had the opportunity to ask questions, and I understand the benefits and risks of the influenza vaccine.

Signature:_____ Date:_____

BELOW TO BE COMPLETED BY A HEALTH CARE PROVIDER. **DATE:**

Type and route of influenza vaccine to be given	Dose	Site	Manufacturer	Lot number	Interviewer Signature	Vaccinator Signature
☐ Inactivated IM Injection ≥ 35 months (FLUZONE)	0.5 mL	Deltoid L or R	Sanofi-Pasteur			
☐ Inactivated IM Injection ≥ 18 years (AFLURIA)	0.5 mL	Deltoid L or R	CSL Limited			
☐ Live Intranasal (FLUMIST)	0.2 mL	Nasal	Sanofi-Pasteur			
☐ Pneumococcal IM (PPSV)	0.5 mL	Deltoid L or R	Sanofi-Pasteur			
☐ No vaccine given today						

Notes: