2015-2016 Adult Influenza Screening Questionnaire

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Recipient's Name: (Print legibly the last and first name)	**Date of Birth:** (month/ day/ year) **Age: ( )**	**SPONSOR Full SSN/DoD ID:** (Print legibly)

Sponsor's Service: Army Air Force Navy Marine Corps DoD Civ Coast Guard

Recipient's Status: (Person receiving the vaccine) (Active Duty) (Reserve/NG) (DoD Civilian) (LN) (Dependent Family Member) (Retired) (Other)

** If you are dual status (i.e. Reserve/NG & also in Civilian or Dependent please ensure you check Reserve/NG)

1.	**Do you feel sick or have fever today?**	**No**	**Yes**
2.	**Have you ever had a serious reaction to a flu vaccine?**	**No**	**Yes**
3.	**Do you have a history of Guillain-Barré Syndrome (GBS)?**	**No**	**Yes**
4.	**Do you have an allergy to eggs, egg protein, MSG, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde, latex, or other vaccine components?**	**No**	**Yes**
5.	**Are you pregnant or planning on becoming pregnant in the next month?**	**No**	**Yes**
6.	**IS THE PATIENT 50 YEARS OR OLDER? (If yes, skip to question # 11)**	**No**	**Yes**
7.	**Do you have a chronic health problem such as: *asthma, heart disease, lung disease, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes) or a blood disorder?***	**No**	**Yes**
8.	**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 treatment with radiation or drugs?**	**No**	**Yes**
9.	**Are you taking any prescription medicines to prevent influenza? Have you taken any antivirals in the last 48 hours?**	**No**	**Yes**
10.	**Do you live with, or expect to have close contact with, severely immunocompromised individuals living in a protective environment (e.g., in isolation)?**	**No**	**Yes**
11.	**Have you received any live vaccines such as Yellow Fever, Varicella etc. within the last 30 days or do you plan to receive any vaccines in the next 4 weeks?**	**No**	**Yes**

I have read, or have had explained to me, the information in the 2015-2016 Influenza Vaccine Information Sheet (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. (This form is subject to the Privacy Act of 1974)

Recipient's signature_____ Date _____

Below to be completed by health care provider only

☐ **Give injectable flu vaccine today**	**Comments:**	**Validated ID Card: Yes / No**
☐ **Give intranasal flu vaccine today**		**Interviewer's Signature:**
☐ **Do NOT administer flu vaccine today**		

Vaccine Administered

☐ **Live FluMist Prefilled Intranasal Sprayer**	☐ **Inactivated FluLaval Multi-Dose Vial**	☐ **Inactivated Fluarix Prefilled Syringe**	☐ **Inactivated Afluria Prefilled Syringe & Multi-Dose** ***** (Pre- schooler/Adolescent) May be used for 5 yrs and older IF NO OTHER VACCINE IS AVAILABLE**
Ages: 2-49 Yrs of age **Dose:** 0.2ml **Route:** Intranasal 0.1ml each nostril **Lot #** _____	**Ages:** 3 yrs & older **Dose:** 0.5ml **Route:** IM L / R Deltoid **Lot #** _____	**Ages:** 3 yrs & older **Dose:** 0.5ml **Route:** IM L / R Deltoid **Lot #** _____	**Ages:** *** 9 yrs & older **Dose:** 0.5ml **Route:** IM L / R Deltoid **Lot #** _____

Administered by:	**Date:**