

# Non-Scannable Influenza Vaccination Screening Form

Clinic Code

AL

Client Information

For clinical staff use only.

Please **print** clearly in **blue** or **black ink**, using **CAPITAL LETTERS** only, within the spaces provided.

First Name

MI

Last Name

Street Address (or Post Office Box)

City

State

Zip Code

Telephone Number

Date of Birth

Age

Gender

(fill-in bubble)  M  F

Month Day Year

**Answer YES or NO to each question below by marking with an X in appropriate box**

Your answers below will help us determine if you should receive an influenza vaccine today

- 1 Do you live with or provide care for infants under 6 months of age?  YES  NO
- 2 Are you health care or emergency medical services personnel?  YES  NO
- 3 If female, are you pregnant or might be pregnant?  YES  NO
- 4 Do you have a long-term health problem such as heart or lung disease, asthma, reactive airways, kidney disease, metabolic disease (e.g., diabetes), blood diseases or are you on long term aspirin-therapy?  YES  NO
- 5 Do you have an illness such as HIV/AIDS, lupus or cancer, or do you take any medication that might lower your body's resistance to infection?  YES  NO
- 6 Do you have a severe allergy to eggs, gelatin or other components of flu vaccine?  YES  NO
- 7 Are you feeling ill today or do you have a fever?  YES  NO
- 8 Were you ever diagnosed with Guillain-Barre Syndrome (GBS)?  YES  NO
- 9 Have you ever had a bad reaction to a flu vaccination in the past?  YES  NO
- 10 Do you have close contact with immunosuppressed persons who require a protected environment?  YES  NO
- 11 Have you received another vaccination in the past four weeks?  YES  NO
- 12 Have you ever fainted after an injection in the past?  YES  NO

I have received, read and had my questions answered about the Vaccine Information Statement(s) for the doses to be given. I request that the dose(s) be given to me or the person named above, for whom I am responsible. My relationship to the patient is \_\_\_\_\_ (e.g. Mother, Father, Guardian). I also allow release of any information needed to process insurance claims and request payment of medical benefits. I have received this clinic's HIPAA Notice of Privacy Practices information sheet, **check here.**

Oregon Public Health may follow-up with persons receiving H1N1 vaccine; please check if you do not wish to be contacted:

Signature: **X**

Adult, parent, or guardian

Date Signed:

SEE REVERSE FOR REASONS THESE QUESTIONS ARE BEING ASKED