

Circle One:

Active Duty, Military Retiree/Beneficiary, National Guard/Reserve, MEDDAC Employee, DOD Civilian

Adult Influenza Vaccine Screening Form

2015-2016 Seasonal Influenza Vaccination program

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Last Name	First Name	Date of Birth:	Full Sponsor SSN	Is your Primary Care Provider (PCM) at FAHC? (circle) Yes No
Please print				

Circle answers to questions 1-11:

1	Do you currently feel sick or have a fever?	No	Yes
2	Have you ever had a serious reaction to a flu vaccine?	No	Yes
3	Do you have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
4	Have you had any food or medication allergies to egg, egg protein, gelatin, neomycin, gentamicin, arginine, thimerosal, formaldehyde or any vaccine component?	No	Yes
5	Are you pregnant or planning to become pregnant in the next month?	No	Yes
6	Are you age 50 or older? (If Yes, Stop Here) - Individuals age 50 years or older should receive IIV, not LAIV.	No	YES
7	Do you have a chronic health problem such as: asthma, heart disease, lung disease, kidney disease, neurological 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 or treat influenza? Have you taken any antiviral medication 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 vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks?	No	Yes
12	Please list all the medications you are taking:	No	Yes

"I have read or have had explained to me the information in the 7 Aug 2015 Influenza Vaccine Information Statement (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."

Signature: _____ **Date** _____

Below to be completed by healthcare provider:

Vaccine Information Statement provided (circle):
 Inactivated Influenza Vaccine (IIV) Live, Attenuated Influenza Vaccine (LAIV)

Vaccine Administered

Live Intranasal influenza \geq 18yr - 49 yrs (FluMist-LAIVA4, 0.2 mL MedImmune)	Lot #	Expires
Inactivated Influenza (Afluria-IIV3, bioCSL) Dose 0.5mL IM Left/Right Deltoid	Lot#	Expires
(Fluarix-IIV4, GSK) Dose 0.5 mL IM Left / Right Deltoid	Lot #	Expires
(_____) Dose 0.5 ml IM Left / /Right Deltoid	Lot#	Expires

Administered by: _____ **Date:** _____

Vaccine Not Administered. Comment: