

Pediatric and Adolescent Influenza Vaccine Screening Questions

2015-2016 Seasonal Influenza Vaccination Program

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Last Name Please print	First Name	Date of Birth:	Sponsor Full SSN:	Is your Primary Care Provider (PCM) at FAHC? (circle) Yes No
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Circle answers to questions 1-14:

1	Has your child ever received a seasonal influenza vaccine?	No	Yes
2	Does your child currently feel sick or have a fever?	No	Yes
3	Has your child ever had a serious reaction to a flu vaccine in the past?	No	Yes
4	Does your child have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
5	Has your child had any food (egg, egg protein, gelatin) reactions or medication reactions (neomycin, gentamicin), or reactions to latex or any vaccine components formaldehyde, thimerosal, polymyxin B). Does your child have an allergy to any of the following: eggs, egg protein, MSG, gentamicin, neomycin, polymyxin, gelatin, arginine, thimerosal, formaldehyde, or other vaccine components?	No	Yes
6	Is your child younger than 2 years of age? FluMist is not available for children younger than 2 years old.	No	Yes
7	Does your child have a history of asthma, reactive airway disease, or wheezing?	No	Yes
8	Does your child have heart disease, lung disease, kidney disease, liver disease, neurological or neuromuscular disease, metabolic disease (e.g., diabetes), a blood disorder or any other chronic health condition)?	No	Yes
9	Does your child have a weakened immune system because of HIV, or another disease that affects the immune system; take long-term high-dose steroid treatments, or cancer treatment with radiation or drugs?	No	Yes
10	Is your child taking aspirin or aspirin-containing products?	No	Yes
11	Is your child taking any prescription medicines to prevent or treat influenza? Have they taken any anti-viral medications in the last 48 hours?	No	Yes
12	Does your child live with or expect to have close contact with severely immuno-compromised individuals who must be in a protective environment (those isolation)?	No	Yes
13	Is the adolescent to be vaccinated pregnant?	No	Yes
14	Has your child received any vaccines within the past 30 days or are they going to receive any additional vaccines with the next 4 weeks?	No	Yes
15	List all the medications your child is taking:		

"I have read or have had explained to me the information in the 2015-2016 Influenza Vaccine Information Statement (VIS) dated 7 Aug 2015. 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 (VIS) provided. circle:

Inactivated Influenza Vaccine (IIV4)	Live, Attenuated Influenza Vaccine (LAIV4)
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Vaccine Administered:

Live Intranasal Influenza (FluMist LAIVA4 , MedImmune Dose 0.2 mL): Children 2-18yr - Lot#		Expires
Inactivated Influenza (Fluzone pediatric - IIV4 Dose 0.25 mL Sanofi-Pasteur): Infants 6-35 months -		
IM Left / Right Thigh	IM Left / Right Deltoid	Lot# Expires
(Fluarix IIV4, GSK): Children 3yr-18yr - Dose 0.5 mL IM Left / Right Deltoid		Lot# Expires:
(Afluria IIV3, CSL): Children 9 yr - 18 yr - Dose 0.5 mL IM left / Right deltoid		Lot# Expires:
(_____): Children 3 yr - 18 yr Dose 0.5 mL IM left / Right deltoid		Lot # Expires:

Administered by: _____ **Date:** _____

Vaccine Not Administered. Comment: