

Last Name _____ First Name _____ Age _____ Today's Date _____

H1N1 Flu Vaccination Screening Form for Adults and Children

If your child has already been vaccinated with 2009 H1N1 flu vaccine, please tell us the number of doses and dates of vaccination.

Dose 1 Date received: month ____ day ____ year ____ Type: nasal spray shot

Dose 2 Date received: month ____ day ____ year ____ Type: nasal spray shot

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child H1N1 influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask for an explanation.

Is the person to be vaccinated feeling well today? Yes No If no, please let a screener know before standing in line.

Please choose the type of vaccine you would like to receive and answer the questions below.

	Injectable Flu Shot For people 6 months and older	Yes	No	Don't Know
1.	Does the person to be vaccinated have a serious allergy to eggs?			
2.	Does the person to be vaccinated have a serious allergy to gentamicin, neomycin, polymixin or gelatin?			
3.	Has the person to be vaccinated ever had a serious reaction to a previous dose of flu vaccine?			
4.	Has the person to be vaccinated ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			

	Nasal Spray For healthy people age 2 to 49 years	Yes	No	Don't Know
1.	Does the person to be vaccinated have a serious allergy to eggs?			
2.	Does the person to be vaccinated have a serious allergy to gentamicin, neomycin, polymixin or gelatin?			
3.	Has the person to be vaccinated ever had a serious reaction to a previous dose of flu vaccine?			
4.	Has the person to be vaccinated ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
5.	Has the person to be vaccinated been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ____ day ____ year ____			
6.	Does the person to be vaccinated have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?			
7.	If the person to be vaccinated is 2-4 years of age, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?			
8.	If the person to be vaccinated is a child, is s/he on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?			
9.	Does the person to be vaccinated have weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?			
10.	Is the person to be vaccinated pregnant?			
11.	Does the person to be vaccinated have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?			

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Reviewed By _____