



Screening Form for Influenza Vaccination

Treat as Confidential

The following questions will let us know if you/your child can receive the H1N1 vaccine and whether you/your child should receive a shot or an intranasal spray. Please mark YES, NO, or N/A for each question.

VACCINE RECIPIENT/CHILD'S NAME: _____ Date: _____

	YES	NO	N/A
General Influenza Vaccine Questions: The answers to these questions will help determine if you may receive flu vaccine.			
1. Have you/Has your child ever received influenza vaccine before? *If yes, previous date seasonal vaccine administered: Date received: month ____ day ____ year ____ Form (please circle): nasal spray shot <b style="text-align: center;">OR *If yes, previous date H1N1 vaccine administered: <input type="checkbox"/> Dose 1 Date received: month ____ day ____ year ____ Form (please circle): nasal spray shot <input type="checkbox"/> Dose 2 Date received: month ____ day ____ year ____ Form (please circle): nasal spray shot			
2. Have you/Has your child had a reaction to an influenza vaccine before? If yes, describe: _____			
3. Do you/Does your child have any illness today more serious than a cold? If yes, describe _____ (nurse will check with child before vaccination)			
4. Do you/Does your child have a severe, life-threatening allergy to latex? If yes, describe: _____			
5. Do you/Does your child have a severe, life-threatening allergy to eggs? If yes, describe: _____			
6. Have you/Has your child ever been paralyzed with a disease called Guillain-Barré Syndrome (GBS)? If yes, describe: _____			
Intranasal Vaccine Questions: The answers to these questions will help determine which form of vaccine may be given (intranasal or by a shot).			
1. Are you/is your child younger than age 2 years or older than age 49 years?			
2. Do you/does your child have a long-term health problem with heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorders?			
3. For children age 2 through 4 years only: In the past 12 months, has a healthcare provider ever said that he or she had wheezing or asthma?			
4. Do you/Does your child have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, or are on long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?			
5. For individuals younger than 18 years: Are you/is your child regularly taking medications that contain aspirin?			
6. Are you/is your child pregnant or could she become pregnant within the next month?			
7. Do you/does your child have close contact with someone who is severely immunocompromised (such as someone in bone marrow transplant unit of a hospital)?			
8. Do you/does your child have certain muscle or nerve disorders (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems, or a history of Guillain-Barré Syndrome (GBS)?			
9. Have you/Has your child received any other vaccinations in the past 28 days? If yes, please list: _____			

REVIEWED/SCREENED BY: _____ Date: _____
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