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| Influenza Vaccine: (6 months and older) |

**PATIENT INFORMATION**

Last First Birthday Age

**SCREENING CHECKLIST**

[If the answer to any of the questions above is “yes,” reference “Information for Healthcare Professionals about the Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination” or consult with the physician before the immunization is given.]

1. Is the person to be vaccinated sick today? Y N
2. Does the person to be vaccinated have an allergy to an ingredient in the vaccine? Y N
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past? Y N
4. Has the person to be vaccinated ever had Guillain-Barre syndrome? Y N

**SIGNED CONSENT**

I have read and understand the possible side effects described in the Vaccine Information Sheet (VIS). I have had a chance to ask questions which were answered to my satisfaction. I understand the risks and benefits of the vaccine(s) and request that the vaccine(s) be given to me, or the person named above for whom I am authorized to make this request.

Signature of person to receive vaccine(s) or person Date Time

authorized to make the request.

Relationship to person receiving vaccine(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Left Arm Right Arm