Screening Questionnaire for Injectable Influenza Vaccination

PEDIATRIC & ADULT MEDICINE, INC.

Patient Name _________________________________ DOB_________ Chart # _____________

Form Completed by ____ Date _______________

	Yes	No	Don't Know
Is the person to be vaccinated sick today?	☐	☐	☐
Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

Form reviewed by ____ Date: _________________________

Vaccine to be given ☐ Seasonal ☐ Already Given ☐ H1N1 ☐ Already Given

Technical content reviewed by the Centers for Disease Control and Prevention
Immunization Action Coalition

Cuestionario previo a la Vacunacion Inyectable contra Influenza

PEDIATRIC & ADULT MEDICINE, INC.

Nombre del Paciente___________________Fecha de Nacim____________Archivo#___________

Forma preparada por _________________________________ Fecha _______________________

	Si	No	No se
1. Esta enferma la persona a vacunar hoy?	☐	☐	☐
2. La persona a vacunar tiene alergia a los huevos o algun compuesto de la vacuna de influenza?	☐	☐	☐
3. La persona a vacunar algun vez tuvo una reaccion adversa a la vacuna de influenza (FluMist) en el pasado?	☐	☐	☐
4. La persona a vacunar alguna vez tuvo el Sindrome de Gullain-Barre?	☐	☐	☐

Form reviewed by ____ Date: _________________________

Vaccine to be given ☐ Seasonal ☐ Already Given ☐ H1N1 ☐ Already Given

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