PEDIATRIC AND YOUNG ADULT MEDICINE

LABEL

## *Screening Questionnaire for Influenza Vaccine*

**The following questions will help us determine if there is any reason we should not give your child an influenza vaccine. If you answer "yes" to any question, id does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.**

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| 1. Is the patient to be vaccinated sick today? | □ Yes □ No □ Don't know |
| 2. Does the patient to be vaccinated have an allergy to eggs or to a component of the influenza vaccine? | □ Yes □ No □ Don't know |
| 3. Has the Patient to be vaccinated ever had a serious reaction to an influenza vaccine in the past? | □ Yes □ No □ Don't know |
| 4. Has the patient to be vaccinated ever had Guillain-Barre Syndrome? | □ Yes □ No □ Don't Know |
| ***If you are receiving the Intranasal (Flu Mist)vaccine please answer the following questions*** | |
| 5. Is this patient younger than age 2 years? | □ Yes □ No □ Don't Know |
| 6. Does this patient to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes, or anemia or another blood disease? | |
| 7. If the patient to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you he or she had wheezing or asthma? | □ Yes □ No □ Don't Know |
| 8. Does the patient to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs? | □ Yes □ No □ Don't Know |
| 9. Is the person to be vaccinated receiving antiviral medications? | □ Yes □ No □ Don't Know |
| 10. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy? | □ Yes □ No □ Don't Know |
| 11. Is the patient to be vaccinated pregnant or could she become pregnant within the next month? | □ Yes □ No □ Don't Know |
| 12. Does the patient to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? | □ Yes □ No □ Don't Know |
| 13. Has the patient to be vaccinated received any another vaccinations in the past 4 weeks? | □ Yes □ No □ Don't Know |
| **Form completed by: _____ ____ Date_____**<br>**Relationship to Patient _____**<br>**Form reviewed by: _____ Date_____** | |