

# FLU VACCINE SCREENING FORM 2007

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_  
(mo) (day) (yr.)

**Parents/Guardians:** Please answer the following screening questions next to your child's age by circling the correct answer(s). Please ask the nurse or doctor to explain if any questions are not clear. There are 3 additional questions on page 2.

If your child's age is between	SCREENING QUESTIONS			Office Use Only dnv = do not vaccinate pp = private purchased ss = state supplied pf = preservative free
		YES	NO	
Birth up to 6 months	1. Is your child less than 6 months of age today?	Y	N	Y – do not vaccinate
	2. Are there other children in the home under 19 years of age? (If yes, request individual screening form for each child.)	Y	N	Y – screen by age
6 months up to 3rd birthday	1a. Is this your child's 1 <sup>st</sup> dose of flu vaccine? 1b. How many doses did your child receive last year? 1c. Did your child receive vaccine 2 years ago?	Y 1 Y	N 2 N	<b>SS</b> 1a. Y 2 doses 1a. N go to 1b 1b. 1-go to 1c 1b. 2 -1 dose 1c. Y 1 dose 1c. N 2 doses <b>Fluzone PF 0.25 ml</b> (Sanofi)
	2. Are there other children in the home under 19 years of age? (If yes, request individual screening form for each child.)	Y	N	Y – screen by age
3 years up to 5 <sup>th</sup> birthday	1a. Is this your child's 1 <sup>st</sup> dose of flu vaccine? 1b. How many doses did your child receive last year? 1c. Did your child receive vaccine 2 years ago?	Y 1 Y	N 2 N	<b>SS</b> 1a. Y 2 doses 1a. N go to 1b 1b. 1-go to 1c 1b. 2 -1 dose 1c. Y 1 dose 1c. N 2 doses <b>Fluzone 0.5 ml</b> (Sanofi)  <b>Fluvirin 0.5 ml</b> (Novartis) <b>≥4 years of age</b>
	2. Are there other children in the home under 19 years of age? (If yes, request individual screening form for each child.)	Y	N	Y – screen by age
5 years up to 9 <sup>th</sup> birthday	1. Does your child have any of the following conditions? a) Heart or breathing conditions, including asthma b) Diabetes c) Blood conditions e.g. Sickle Cell Anemia d) Chronic aspirin therapy e) Cancer, leukemia, AIDS, or any other immune system problem f) Cognitive dysfunction, spinal core injuries, seizure disorders, or other neuromuscular disorders that can increase the risk for aspiration	Y	N	Y– SS N – PP  <b>Fluzone 0.5 ml</b> (Sanofi) <b>Fluvirin 0.5 ml</b> (Novartis) <b>Flumist</b> (Medimmune)
	2. Does your child live with an infant less than six months of age, someone who has any of the medical conditions listed in # 1 above, is pregnant or is over 65 years of age?	Y	N	Y– SS N – PP  <b>Fluzone 0.5 ml</b> (Sanofi) <b>Fluvirin 0.5 ml</b> (Novartis) <b>Flumist</b> (Medimmune)
	3a. Is this your child's 1 <sup>st</sup> dose of flu vaccine? 3b. How many doses did your child receive last year? 3c. Did your child receive vaccine 2 years ago?	Y 1 Y	N 2 N	3a. Y 2 doses 3a. N go to 3b 3b. 1- go to 3c 3b. 2 -1 dose 3c. Y 1 dose 3c. N 2 doses
	4. Are there other children in the home under 19 years of age? (If yes, request individual screening form for each child.)	Y	N	Y – screen by age

If your child's age is between	SCREENING QUESTIONS	YES	NO	Office Use Only
<b>9 years up to 19<sup>th</sup> birthday</b>	1. Does your child have any of the following conditions? a) Heart or breathing conditions, including asthma b) Diabetes c) Blood conditions e.g. Sickle Cell Anemia d) Chronic aspirin therapy e) Cancer, leukemia, AIDS, or any other immune system problem f) Cognitive dysfunction, spinal core injuries, seizure disorders, or other neuromuscular disorders that can increase the risk for aspiration	Y	N	Y – SS N – PP 1 dose <b>Fluzone 0.5 ml</b> (Sanofi) <b>Fluvirin 0.5ml</b> (Novartis) <b>Flumist</b> (Medimmune)
	2. Are there any children in the home under 5 years of age? (If yes, request individual screening form for each child)	Y	N	
	3. Does your child live with someone who has any of the conditions listed in # 1, is pregnant or is over 65 years of age?	Y	N	
	4. Is your child/teen pregnant?	Y	N	<b>PF Fluzone 0.5 ml</b> (Sanofi)

### Additional Questions (for ALL children)

1. Is your child sick today?	Y	N	Y -requires further assessment
2. Does the child have allergies to medications, food, or any vaccine? ( <b>eggs, gelatin, thimerosal, neomycin, polymyxin B</b> )	Y	N	
3. Has your child had a serious reaction to a vaccine in the past?	Y	N	
4. Is your child on any medication? If yes, please list:	Y	N	

I have been given a copy of and have read, or have had explained to me the information in the Vaccine Information Statement for Influenza. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine. I request that the vaccine indicated below be given to me or to the person named below for whom I am authorized to make this request.

**Child's Name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

OFFICE STAFF TO COMPLETE								
Influenza Vaccine	Date Given	Dose in Series	Dosage	Route	Site	Vaccine Manufacturer and Lot #	VIS Material Pub Date	Signature and Title of Person Administering Vaccine
Fluzone – PF		1		IM				
Fluzone		2		Nasal				
Fluvirin								
LAIV								

Recall for 2<sup>nd</sup> dose