



Influenza Vaccine Screening Questionnaire, Consent and Administration Record

Please read and answer every question. If you are an adult completing this form for your child, please answer questions as they apply *to your child*:

- 1. Are you ill today? No Yes If so, describe _____
- 2. Do you have an allergy to the influenza vaccine? No Yes
- 3. Are you allergic to eggs or egg products? No Yes
- 4. Have you had a severe reaction to any type of vaccine? No Yes
- 5. Do you have a history of Guillain-Barre Syndrome? No Yes
- 6. Do you currently have a fever, infection or other illness? No Yes

Please Print:

Name: _____ DOB: _____

SSN: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

I have read or had explained to me the Influenza Vaccine Statement regarding influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine, and I request that the influenza vaccine be given to me or the person named below (if a minor) for whom I have authorization to make this request. I understand that my insurance may not cover the vaccine(s) and/or other related services. I further understand that I will be responsible for payment of any non-covered charges.

Signature of patient or parent/guardian

Date

I understand that my insurance may not cover the vaccine(s) and/or other related services. I further understand that I will be responsible for payment of any non-covered charges.

Signature of patient or parent/guardian

Date

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Payer: Medicare Private Insurance Medicaid Private Pay VFC Adult ODH

Vaccine from: VFC Stock Purchased Stock Adult ODH Stock

Date of Vaccine: ___ / ___ / ___ Name of Influenza Vaccine: _____

Vaccine Lot Number/Expiration Date: _____ Site/Route of Injection: _____ IM

Signature/Title of Vaccine Administrator: _____