Patient name: _____DOB _____/_____/_____

PATIENT ONLY SCREENING QUESTIONNAIRE FOR INACTIVATED INJECTABLE INFLUENZA VACCINATION ("Flu Shot")

The following questions will help us determine if there is any reason we should not give your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it 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 us to explain it.

		Yes	No	Don't Know
1.	Is the person to be vaccinated UNDER 6 months of age?	☐	☐	☐
2.	Is the person receiving the flu shot today have SUPERIOR, AMERIGROUP, MEDICAID or CHIP insurance? *If YES, please be sure we have most recent information on file otherwise a charge may apply.*	☐	☐	☐
3.	Has the person to be vaccinated ever had a SEVERE allergy to EGGS (anaphylaxis or hives), or ever have a SERIOUS REACTION to any flu vaccine or its components (shot or mist)? ***Please ask for the "Flu Vaccine and Egg Allergy Info Sheet" for more information.**	☐	☐	☐
4.	Has the person to be vaccinated ever had Guillain-Barre syndrome within 6 wks of receiving any flu vaccine?	☐	☐	☐
5.	Is the person to be vaccinated moderately ill (fever >102). If you answer YES to this question, we require approval of the Medical Director present at the clinic today to approve the vaccine.	☐	☐	☐
6.	If this child is less than 9 years old, did they receive a Flu vaccine during August 2010-June 2011*? If not a booster is recommended.* **** Please ask for the Flu Booster Reminder and return to clinic as instructed.**	☐	☐	☐
7.	I have paid for today's vaccine OR I understand that Pediatric Junction will file insurance USING THE MOST RECENT INSURANCE INFORMATION AVAILABLE for payment for my child's flu vaccine today. I understand that I will be responsible for any balance (up to $30) that my child's insurance doesn't cover.	☐	☐	☐
8.	I have reviewed the Vaccine Information Sheet ("VIS") for Inactivated Injectable Influenza Vaccine dated 7/26/11.	☐	☐	☐
9.	**ANSWER ONLY IF TODAY'S VACCINE IS THE BOOSTER DOSE :** It has been at least 4 weeks from my child's first flu vaccine this season	☐	☐	☐

_____ _____ _____

PRINT NAME (parent/guardian) SIGNATURE DATE

FOR INTERNAL USE ONLY – CLINICAL STAFF

VACCINE ORDER AND ADMINISTRATION RECORD

VACCINE ORDERED: ____ PVT Flu 0.25mL (pink) ____STATE Flu 0.25Ml (pink labeled "S")

____ PVT Flu 0.5mL (blue) ____STATE Flu 0.5mL (blue labeled "S")

VACCINE ORDERED BY: _____

VACCINE GIVEN: Inactivated Influenza Vaccine, Intramuscular L R Deltoid Thigh

_____ **PRIVATE 0.25mL Preservative free** _____ **STATE 0.25 mL Preservative free**

_____ **PRIVATE 0.5mL Preservative free** _____ **STATE 0.5 mL Preservative free**

VACCINE GIVEN BY: _____

LAST UPDATED 09/12/2011 VACCINE BILLED AND ENTERED BY: _____