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VACCINE SCREENING CHECKLIST

PLEASE fill out the following and give to doctor or nurse

Name (Last, First, Middle): _____

Insurance : Co._____,ID#_____

AGE_____ DOB: _____

Answer the following questions.

PLEASE READ the VIS (Vaccine Information Sheet) then answer the following questions.
The CDC, ACIP & American Academy of Pediatrics recommend that the **Flu Mist NOT be used**.

If you are receiving a Flu Vaccine Injection answer the questions marked with (*) if you are receiving the Flu Mist or any other Vaccine answer all of the questions.		
*Are you pregnant?	YES	NO
*Are you sick today?	YES	NO
*Are you allergic to eggs?	YES	NO
*Have you ever had a serious reaction after receiving **any** vaccines?	YES	NO
Have you ever had Guillain-Barre syndrome after receiving a Flu Vaccine	YES	NO
Answer these questions only if you are receiving the Flu Mist (Flu Mist not recommended)		
Have you received the MMR, VZV or any LIVE vaccines in the past 4 WEEKS?	YES	NO
Do you have any long term health problems (Heart Disease, Asthma, Kidney Disease, Blood Disorders)?	YES	NO
Do you have any Immune System Problems (HIV/Leukemia/Cancer/Etc.)?	YES	NO
Are you on any medicines that weaken your immune system or have you taken any within the last 3 MONTHS (steroids, prednisone, cortisone, radiation treatments, or anticancer medicine)?	YES	NO
Are you taking any other medications? (Including aspirin or aspirin containing medications)	YES	NO
During the past YEAR have you had a Blood Transfusion or Blood Products or been given Immune Gamma Globulin?	YES	NO
Have you taken any antiviral – influenza medications (Tamiflu) in the last 48hrs? **Be advised if you take* Tamiflu *within 14 days of receiving the Flu Mist you will need to be re-treated with a Flu Vaccine by Injection.*	YES	NO
Will you be in close contact with a person whose immune system is severely compromised? (such as person on chemotherapy)	YES	NO

Please read and sign the following:

I have had the opportunity to read the Vaccine Information Sheet and ask for a personal copy if I desire. I consent to the administration of the recommended vaccine; I understand that my insurance will be billed and that I am responsible for any charges that are not covered by my insurance.

Patient Signature: _____

Date: _____

Phone Number: _____

For Office Use Only:

Vaccine Given: _____

Lot #: _____ Site_____ IM SQ ID PO Administered By: _____