

Patient name: _____ Date of birth: ____/____/____
 (mo.) (day) (yr.)

Screening Questionnaire for Inactivated Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or 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.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Patient's Full Name _____ Date of Birth _____

Consent to Receive Influenza Vaccine

I have read the Vaccine Administration Sheet (7/26/11) or have had the information explained to me. I have had a chance to ask questions and these questions have been answered to my satisfaction. I, hereby acknowledge that I have been informed of the possible risks, side effects and adverse reactions including, but not limited to, Guillain-Barré Syndrome, associated with the use of the influenza vaccine.

I understand that this season's vaccine is a combination of A/H1N1 (pandemic) influenza and two other influenza viruses-influenza A/H3N2 and influenza B.

I understand the benefits and risks of not taking the vaccine and ask that the vaccine be given to me.

I have completed the Screening Questionnaire for the **Injectable / Intranasal** (Please Circle) Influenza Vaccine and these special precautions do not apply to me.

I, therefore, release **Cabarrus Pediatrics** from any liability for possible complications.

I do agree to wait in the office for a period of 15 minutes after the injection in case I have any immediate side effects.

Patient's
(or Legal Representative's) Signature: _____ Date: _____

Administered by: _____ Date: _____

Manufacturer: _____ Lot #: _____

Site: _____ Dose: _____ Exp. Date: _____

Tolerated: _____ Well, no reported problems

_____ Not well, provider notified