

Patient Name: _____ Date of Birth: ____/____/____
 (mm) (dd) (yr)
 Medicare Claim Number: _____

Screening Questionnaire for Immunization

For adult patients to be vaccinated: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you 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.

1. Is the person to be vaccinated sick today? YES NO
2. Does the person to be vaccinated have any allergies to medications, food, a vaccine component, or latex? YES NO
3. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination in the past? YES NO
4. Does the person have any long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? YES NO
5. Does the person have cancer, leukemia, AIDS, or any other immune system problem? YES NO
6. Does the person take cortisone, prednisone, other steroids, or anti-cancer drugs, or have you had radiation treatments? YES NO
7. Has the person had a seizure or a brain or other nervous system problem? YES NO
8. During the past year, has the person received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? YES NO
9. For women: Is the person pregnant or is there a chance she could become pregnant during the next month? YES NO
10. Has the person received any vaccinations in the past 4 weeks? YES NO

Patient Signature : _____ Date: _____

To be completed by Pharmacist

Vaccine _____ Manufacturer & Lot Number _____

Administration Site Left Arm Right Arm

Dosage 0.5ml 2.5ml LAIV

Pharmacist's Signature _____ Date: _____