

## Adult Screening and Immunization Documentation Form 2010-2011 Seasonal Influenza Vaccination Program

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<b>Name (Please Print):</b>	<b>Sponsor's SSN:</b>
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### Circle answers to questions 1-11:

1	Do you currently feel sick or have a fever?	No	Yes
2	Have you ever had a serious reaction to a flu vaccine?	No	Yes
3	Do you have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
4	Do you have an allergy to any of the following: eggs, egg protein, MSG, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde, latex or other vaccine components?	No	Yes
5	Are you pregnant or planning to become pregnant in the next month?	No	Yes
6	Are you 50 years of age or older? <b>(If marked Yes, skip questions 7-11)</b>	No	Yes
7	Do you have a chronic health problem such as: asthma, heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes) or a blood disorder?	No	Yes
8	Do you have a weakened immune system because of HIV or another disease that affects the immune system, long-term high-dose steroid treatments, or cancer treatment with radiation or drugs?	No	Yes
9	Are you taking any prescription medicines to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	No	Yes
10	Do you live with or have close contact with severely immunocompromised individuals or someone who must be in a protective environment (such as transplant recipients?)	No	Yes
11	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks?	No	Yes

**If you are not sure that the person is registered or received services (pharmacy, lab, clinic, etc.) at Kenner Army Health Clinic, please complete the back of this sheet.**

*"I have read or have had explained to me the information in the 2010-2011 Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine."*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Below to be completed by healthcare provider

<input type="checkbox"/> <b>Give injectable flu vaccine today</b> <input type="checkbox"/> <b>Give intranasal flu vaccine today</b> <input type="checkbox"/> <b>Do not administer flu vaccine today</b>	<b>Vaccine Information Statement provided (check box)</b> <input type="checkbox"/> Inactivated Influenza Vaccine (TIV) <input type="checkbox"/> Live, Attenuated Influenza Vaccine (LAIV)		
	<table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 70%;">Interviewer's Signature</td> <td style="border: none; width: 30%;">Date</td> </tr> </table>	Interviewer's Signature	Date
Interviewer's Signature	Date		

### Vaccine Administered

<input type="checkbox"/> <b>Live Intranasal Influenza</b> (FluMist, MedImmune) Lot # _____ Dose: 0.2 ml      Route: Intranasal	<input type="checkbox"/> <b>Inactivated Influenza</b> (Fluzone, Sanofi-Pasteur) <input type="checkbox"/> <b>Inactivated Influenza</b> (Fluzone High-Dose, Sanofi- Pasteur) <input type="checkbox"/> <b>Inactivated Influenza</b> (Afluria, CSL) Lot # _____ Dose: 0.5 ml      Route: IM      Left / Right Deltoid
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**Comments:**

<b>Administered by:</b>	<b>Date</b>
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**If you're not SURE that you've been seen or registered at Kenner Army Health Clinic**

**– please complete this portion**

**LAST NAME, FIRST NAME, M.I.** \_\_\_\_\_

**SPONSOR'S SSN: 20/** \_\_\_\_\_ **DOB** \_\_\_\_\_

**SEX (CIRCLE ONE)    MALE        FEMALE        RANK** \_\_\_\_\_

**UNIT** \_\_\_\_\_ **UNIT PHONE** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_

**LOCATION OF MEDICAL RECORDS** \_\_\_\_\_

**LIST ALL ALLERGIES AND SIDE EFFECTS SEEN:**        **NO ALLERGIES** \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

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**DO YOU HAVE ANY OTHER HEALTH INSURANCE?**    \_\_\_ YES        \_\_\_ NO

**IF YES, PLEASE PROVIDE THE NAME OF THE HEALTH INSURANCE COMPANY** \_\_\_\_\_