

Adult Screening and Immunization Documentation Form

2009-2010 Seasonal Influenza Vaccination Program

The following questions will help us determine if we should give you the intranasal or the injectable influenza vaccination today. If you answer "yes" to any question, we will ask additional questions to determine which vaccine, if any you will receive. Please speak to your healthcare provider, if you have any questions.

Circle answers to questions 1-13:

1	Are you 49 years of age or younger?	No	Yes
2	Do you currently feel sick or have a fever?	No	Yes
3	Are you taking any prescription medicines to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	No	Yes
4	Are you pregnant or planning to become pregnant in the next month?	No	Yes
5	Have you ever had a serious reaction to a flu vaccine?	No	Yes
6	Do you have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, polymyxin B, thimerosal, formaldehyde, or other vaccine components?	No	Yes
7	Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	No	Yes
8	Do you have an active neurological disease?	No	Yes
9	Do you have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
10	Has your doctor ever told you that you have an immune system disorder? Are you taking long-term steroid treatment or immunosuppressants?	No	Yes
11	Do you have HIV, AIDS, cancer, or have you received an organ transplant?	No	Yes
12	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
13	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

"I have read or have had explained to me the information in the 2009-2010 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

<p>Give injectable flu vaccine today</p> <p>Give intranasal flu vaccine today</p> <p>Do not administer flu vaccine today</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; border: none;">Interviewer's Signature</td> <td style="width: 20%; border: none;">Date</td> </tr> </table>	Interviewer's Signature	Date
Interviewer's Signature	Date		

Vaccine Administered

<p>Live Intranasal Influenza (FluMist, MedImmune)</p> <p>Lot # _____</p> <p>Dose: 0.2 ml Route: Intranasal</p>	<p>Inactivated Influenza (Fluzone, Sanofi-Pasteur)</p> <p>Lot # _____</p> <p>Dose: 0.5 ml Route: IM Left/Right Deltoid</p>
	<p>Comments</p>

<p>Name:</p> <p>DOB:</p> <p>SSN:</p>	<p>Administered by:</p>	<p>Date</p>
---	--------------------------------	--------------------

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. _____

DO YOU HAVE ANY OTHER HEALTH INSURANCE? ___YES ___NO

IF YES, PLEASE PROVIDE THE NAME OF THE HEALTH INSURANCE COMPANY _____