Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

Name: ____

Date of Birth: ______________________________________

ADDRESS: ____

PHONE:____

INSURANCE INFO: _____________________________________

For patients (both children and adults) 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 health care provider to explain it.

1. Is the person to be vaccinated sick today?

2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?

4. Has the person to be vaccinated ever had Guillain-Barré syndrome?

By signing below I give DCPH permission to bill my insurance. I understand that it is my responsibility to give the correct insurance information for billing for the influenza vaccine and if my insurance refuses to pay that I will be responsible for the cost of this vaccination.

Signature:____

Influenza Vaccine:

Private Fluzone:UJ475AB 30Jun21	Deltoid	Thigh	RT	LT
VFC:	Deltoid	Thigh	RT	LT
317: Afluria: P100240230 20May21	Deltoid	Thigh	RT	LT

Administered by: Mary Randolph, RN or Joe Fowler, RN

Date:______________________________________

VIS Date: 08/15/2019