Influenza Vaccine Screening Questionnaire - ADULT

Parent Name:____ **Maiden Name (if appl):** ____________________________

Parent DOB:_____________________________ **Date:**________________________ **Phone:** _______________________________

Address: _______________________________ **City**___________________________ **State**________ **Zip**___________________

Do you have the same insurance as your child? ________ **Yes** ________ No

Full name of child at the practice____

Flu Vaccine 2020-2021
The quadrivalent influenza vaccine for 2020-2021 includes an A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like virus, A/Hong Kong/2671/2019 (H3N2)-like virus, B/Washington/02/2019 (B/Victoria lineage)-like virus, B/Phuket/3073/2013-like (Yamagata lineage) virus

<u>For vaccine recipients</u>: Please answer the following questions. If the questions are unclear, please ask your healthcare provider.

1. Have you had a fever in the last 24 hours? ________ Yes ________ No ________Unsure
2. Do you have any allergies to medications, food, chemicals, latex, or any vaccine? If yes, please describe. ________ Yes ________ No ________Unsure
   ____.
3. Have you had a serious reaction to the flu vaccine in the past? If yes, please describe: ________ Yes ________ No ________Unsure
   ____.
4. Have you had a neurological illness, such as Guillain-Barre' Syndrome (a progressive paralysis of the body)? ________ Yes ________ No ________Unsure
5. Have you received a flu vaccine after July 1, 2020? ________ Yes ________ No ________Unsure

I was counseled on the vaccine including potential side effects and was given the opportunity to ask questions which were answered to my satisfaction. I understand that if my insurance is different from that of my child, I am responsible for paying for my flu vaccine at the time of service.

Signature: ____ Date: _____________________

<u>For office use only:</u>

Type: ____________________ Lot: ____________________Location: ____________________ Administered by: ____________________