

# Sutter County Public Health

## Seasonal Influenza Vaccine Screening Form

Date \_\_\_\_\_

Name of person to receive vaccine (PRINT) \_\_\_\_\_

Age \_\_\_\_\_

Sign below if 18 or older. If person to receive vaccine is under 18, parent or legal guardian please sign below:

**(Signature here)** \_\_\_\_\_

<b><i>Please answer all questions</i></b>	Yes	No	N/A
1. For women: are you pregnant?			
2. Are you allergic to eggs?			
3. Do you have a fever today?			
4. Have you ever had Guillain-Barre Syndrome?			
5. Have you received a live vaccine in the last 4 weeks?			
6. Have you ever had a serious reaction to the flu vaccine?			
7. Do you take a medicine that weakens your immune system?			
8. If person to receive vaccine is a child, is the child on aspirin therapy?			
9. Do you have a chronic medical condition that weakens the immune system?			
10. Have you received antiviral medicine such as Tamiflu in the last 48 hours?			
<b><i>We suggest you wait on-site for 15 minutes to make sure you do not have an adverse reaction to the vaccine.</i></b>			

### Staff use only below!

Form reviewed by (please print first and last name) \_\_\_\_\_

Medical Condition \_\_\_\_\_

Please circle one:

nasal	.5 dose	.25 dose under 3 years
<b>NO VACCINE</b>		