Patient ID________________ Date____________ Temp______C

Seasonal Inactivated Influenza Vaccine Questionnaire

The following questions will help us determine if we can safely vaccinate you or your child today. A "Yes" answer does not necessarily mean vaccination is not possible – we will just need to ask some additional questions. Please ask the doctor to explain anything that is not clear to you prior to the vaccination.

Name		Date of Birth	/ / (Mo. / Day / Yr)

	Yes	No	Don't know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have any allergies to medications or foods?			
3. Has the person to be vaccinated ever received an influenza vaccination?			
4. Has the person to be vaccinated ever had a severe reaction to any vaccine?			
5. Has the person to be vaccinated ever had Guillain-Barre syndrome?			

I have received information regarding the seasonal influenza vaccine and understand the risks and benefits of vaccination. My questions have been answered and I agree to the administration of the vaccine.

_______________________________________ ____________________

Signature (Guardian if patient is under 18 years of age) Date

FOR CLINIC USE ONLY:

VACCINATION DATE:	/ /		SITE:	RIGHT	ARM
LOT NUMBER.:				LEFT	LEG
VOLUME:	0.25mL 0.5mL		BY:		M.D. / R.N.