MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance date, local Form Number and Edition Date.

REQUIRING DOCUMENT (*Title and Number*)	ISSUANCE DATE
NAVMEDCENPTSVAINST 6230.3B IMMUNIZATION SERVICES	DECEMBER 14, 2014

LOCAL FORM TITLE (*Optional*)

NAVAL MEDICAL CENTER PORTSMOUTH VIRGINIA
SCREENING QUESTIONNAIRE FOR INFLUENZA VACCINE

The following questions will help us determine if there is any reason we should not give you or your child the influenza vaccine today. If you answer "yes" to any questions 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 provider to explain it.

1. Is the person to be vaccinated sick today?	☐ Yes ☐ ***No*** ☐ Don't Know
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐ Yes ☐ ***No*** ☐ Don't Know
3. Has the person to be vaccinated ever had a serious reaction to the flu vaccine?	☐ Yes ☐ ***No*** ☐ Don't Know
4. Is the person to be vaccinated younger than age 2 or older than age 49 years?	☐ Yes ☐ No ☐ Don't Know
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐ Yes ☐ No ☐ Don't Know
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months has a health care provider told you that the child had wheezing or asthma?	☐ Yes ☐ No ☐ Don't Know
7. Does the person to be vaccinated have cancer, leukemia, HIV / AIDS, or any other immune system problem; or, in the past 3 months, have they taken medication that weakens the immune system,such as cortisone, prednisone, other steroids, or anti-cancer drugs, or have they had radiation treatments?	☐ Yes ☐ No ☐ Don't Know
8. Is the person to be vaccinated receiving antiviral medications?	☐ Yes ☐ No ☐ Don't Know
9. Is the child or teen to be vaccinated receiving aspirin therapy?	☐ Yes ☐ No ☐ Don't Know
10. Is the person to be vaccinated pregnant or could become pregnant within the next few months?	☐ Yes ☐ No ☐ Don't Know
11. Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐ Yes ☐ ***No*** ☐ Don't Know
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e. g., an isolation room of a bone marrow transplant unit)?	☐ Yes ☐ No ☐ Don't Know
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐ Yes ☐ No ☐ Don't Know
14. Has the person to be vaccinated had an allergy shot in the past 24 hours? Or are they scheduled to receive an allergy shot within the next 24 hours? (interval should be 24 hours)	☐ Yes ☐ No ☐ Don't Know

Form completed by: _____ Date: _____

I am the ___ patient ___ birth / adoptive parent ___ legal guardian ___ step-parent

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT:
	SPONSOR'S NAME	SSN
DOD #	RELATIONSHIP TO SPONSOR	

Date: _____

Vaccine Administered:

Inactivated Influenza Vaccine (Flu Shot)

Vaccine	Dose	Site	Lot #	Manufacturer	VIS date
FLU	0.5	L ARM			

If patient answered "No" to questions 1, 2, 3, and 11, can get inactivated influenza vaccine (flu shot).

Live Attenuated Influenza Vaccine (Flu Mist)

Vaccine	Dose	Site	Lot #	Manufacturer	VIS date

For flu mist, see Information for Health Professionals about Screening Checklist for Contra-indications to LAIV.

Form reviewed and vaccine administered by:

Printed Name or Stamp: _____

Signature: _____

I have been instructed on the possible risk and reactions to the vaccine.

Signature of Patient / Parent or Guardian: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT:
	SPONSOR'S NAME	
	RELATIONSHIP TO SPONSOR	