

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

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 healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Phone # _____

Medicare # _____
(or provide Rx Insurance card)

Highland Drug
(Phone) 432-837-3931
(Fax) 432-837-5693

Immunization administration notification to primary care provider

Name & title of immunizer: Jill Jahn, PharmD

Date of vaccination: 10-18-21

First name: _____ Last name: _____

Address :

~~DOB~~ Age of patient: _____

Primary care physician:

Vaccine administered:
Aflunia

Manufacturer : Seqirus Lot # : _____

Amount : 0.5ml Site : _____ Deltoid Route: IM