

Circle One:

Active Duty, Military Retiree/Beneficiary, National Guard/Reserve, MEDDAC Employee, DOD Civilian

## Adult Influenza Vaccine Screening Form

### 2016-2017 Seasonal Influenza Vaccination program

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<b>Please Print : Last Name</b>	<b>First Name</b>	<b>Date of Birth</b>	<b>FMP/ Full SS#</b>	<b>Is your Primary Care Provider (PCM) at FAHC? (circle)</b> <b>Yes                  No</b>
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**Circle answers to questions 1-5:**

1	Do you currently feel sick or have a fever?	Yes	No
2	Do you have an allergy to any component of the vaccine?	Yes	No
3	Have you ever had a serious reaction to influenza vaccine in the past?	Yes	No
4	Have you ever had Guillain-Barre' Syndrome (GBS)?	Yes	No
5	Please list all prescription medications you are taking:		
	<b>Medications:</b>		

"I have read or have had explained to me the information in the 7 Aug 2015 Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. I have truthfully answered the questions on this form. "

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Below to be completed by healthcare provider:**

Vaccine Information Statement  
Inactivated Influenza vaccine provided

**Form Screened By:** \_\_\_\_\_ **(signature)**

Afluria **≥ age 9 yrs** - Dose 0.5mL IM Left / Right Deltoid Lot# Expires \_\_\_\_\_/ 2017  
Fluarix **≥ age 3 yrs** - Dose 0.5ml IM Left / Right Deltoid Lot# Expires \_\_\_\_\_/ 2017  
Fluzone **≥age 6mo- 35 months Dose 0.25ml** IM Left /Right Thigh Lot # Expires \_\_\_\_\_/ 2017

**Administered by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Vaccine Not Administered. Comment:**