

Circle One:

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

Pediatric Influenza Vaccine Screening Form

2016-2017 Seasonal Influenza Vaccination program

This printed material contains sensitive PII protected under the Privacy Act which is FOR OFFICIAL USE ONLY and must be protected in accordance with the Privacy Act, 5USC § 552a. Unauthorized disclosure or misuse of this SENSITIVE PII may result in criminal and/or civil penalties.

| | | | | |
|---------------------------------|-------------------|----------------------|----------------------|--|
| Please Print : Last Name | First Name | Date of Birth | FMP/ Full SS# | Is your Primary Care Provider (PCM) at FAHC? (circle) Yes No |
|---------------------------------|-------------------|----------------------|----------------------|--|

Circle answers to questions 1-5:

| | | | |
|---|--|-----|----|
| 1 | Does your child feel sick or have a fever today? | Yes | No |
| 2 | Does your child have an allergy to any component of the vaccine? | Yes | No |
| 3 | Has your child ever had a serious reaction to influenza vaccine in the past? | Yes | No |
| 4 | Does your child have a history of Guillain-Barre' Syndrome (GBS)? | Yes | No |
| 5 | If your child is between 6 months and 8 years of age, has your child received at least 2 doses of flu vaccine before July 1, 2016? | Yes | No |

"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."

Parent Signature: _____ **Date** _____

Below to be completed by healthcare provider:

Vaccine Information Statement
Inactivated Influenza vaccine provided

Form Screened By: _____ **(signature or stamp)**

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: