2012-2013 Pediatric and Adolescent Influenza Screening Questionnaire

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Recipient's Name: (last, first)	**Date of Birth:** (month/ day/ year)	**Sponsor's SSN:**

Sponsor's Service: Army Air Force Navy/Marine Corps **Sponsor's Status:** Active Duty Reserve/NG Dependent Civilian Retired

1.	**Is your child younger than 2 years of age?**	**No**	**Yes**
2.	**Has your child ever received a seasonal influenza vaccine?**	**No**	**Yes**
3.	**Does your child currently feel sick or have a fever?**	**No**	**Yes**
4.	**Has your child ever had a serious reaction to a flu vaccination in the past?**	**No**	**Yes**
5.	**Does your child have a history of Guillain-Barré Syndrome (GBS)?**	**No**	**Yes**
6	**Does your child have allergy to any of the following:** ***eggs, egg protein, MSG, gentamicin, neomycin, polymyxin, gelatin, arginine, thimerosal, formaldehyde, or vaccine components?***	**No**	**Yes**
7.	**Is your child taking any prescription medicines to prevent or treat influenza?** ***Have they taken*** **any antivirals in the last 48 hours?**	**No**	**Yes**
8.	**Is the adolescent to be vaccinated pregnant?**	**No**	**Yes**
9.	**Does your child have a history of** ***asthma, reactive airway disease, or wheezing?***	**No**	**Yes**
10.	**Does your child have heart disease, lung disease, kidney disease, liver disease, neurological or neuromuscular disease, metabolic disorders (e.g., diabetes), blood disorder or any other chronic health conditions?**	**No**	**Yes**
11.	**Does your child have a weakened immune system because of HIV or another disease that affects the immune system; take long-term high dose steroid treatments, or cancer treatment with radiation or drugs?**	**No**	**Yes**
12.	**Does your child live with or expect to have contact with severely immunocompromised individuals who must be in a protective environment (those in isolation)?**	**No**	**Yes**
13.	**Has your child received any vaccines within the last 30 days or are they going to receive any additional vaccines within the next 4 weeks?**	**No**	**Yes**
14.	**Is your child taking aspirin or aspirin-containing products?**	**No**	**Yes**

I have read, or have had explained to me, the information in the 2012-2013 Influenza Vaccine Information Sheet (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.
(This form is subject to the Privacy Act of 1974)

Recipient's signature___________________________________ Date __________________________

Below to be completed by health care provider only

	Give injectable flu vaccine today	**Comments:**
	Give intranasal flu vaccine today	**Interviewer's Signature:**
	Do NOT administer flu vaccine today	

Vaccine Administered

☐ **Live Intranasal Flumist**	☐ **Inactivated Influenza Fluzone Shot** ***(Infant/Toddler)***	☐ **Inactivated Influenza Fluzone Shot** ***Only high risk contraindicated for Flumist (Toddler/Pre-schooler)***	☐ **Inactivated Influenza Afluria Shot** ***(Pre-schooler/Adult)*** ***** May be used for 5 yrs and older if no other vaccine is available per ACIP guidelines)***
Ages: 2yrs ---49yrs **Dose:** 0.2ml **Route:** Intranasal **Lot #** ____________	**Ages:** 6 months ------ 35 months (2.9yrs) **Dose:** 0.25ml **Route:** IM L / R Deltoid **Lot #** ____________	**Ages:** 36 months ------ 8 yrs (3yrs) **Dose:** 0.5ml **Route:** IM L / R Deltoid **Lot #** ____________	**Ages:** 9 yrs and older ** **Dose:** 0.5ml **Route:** IM L / R Deltoid **Lot #** ____________

Administered by:	**Date:**