PWHD 2009 H1N1 INFLUENZA VACCINATION SCREENING FORM

Place Colored Vaccine Sticker Here

Version 10/7/2009

SECTION A: PATIENT INFORMATION

Name (Last, First, Middle) :		
Date of Birth: / /	Age:	Gender: ❑ M ❑ F

SECTION B: EMERGENCY CONTACT INFORMATION

Name (Last, First, Middle) :			
Address:		City/State:	Zip:
Phone:	Home:	Work:	Cell:

SECTION C: SCREENING FOR VACCINE ELIGIBILITY

If your child has already been vaccinated with **2009 H1N1 influenza vaccine**, please tell us the number of doses and dates of vaccination.

❑ **Dose I** Date received: month_____day_____year_____ Form (please circle): nasal spray shot

❑ **Dose 2** Date received: month_____day_____year_____ Form (please circle): nasal spray shot

SECTION D: PATIENT HEALTH HISTORY

The following questions will help us know if the patient can get the 2009 H1N1 influenza vaccine.
Please mark either **Yes** or **No** for each question. Do not leave any question unanswered.

If you answer "NO" to all of the following questions, the patient can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, the patient may be able to get the H1N1 vaccine, but we will contact you to discuss your options.

	Yes	No
1. Is patient sick today?	❑	❑
2. Has the patient ever had a serious allergic reaction to eggs or the antibiotic gentamicin?	❑	❑
3. Has the patient ever had a serious reaction to a previous dose of seasonal flu vaccine?	❑	❑
4. Has the patient ever had Guillain-Barre Syndrome (GBS), (i.e. paralysis) within 6 weeks after receiving a flu vaccine?	❑	❑
5. Does the patient have any other serious allergies that you know of? Please list: _____ _____	❑	❑
6. Is the patient taking any prescription medication to prevent or treat flu?	❑	❑
7. Does the patient have asthma, wheezing, difficulty breathing, or lung disease?	❑	❑
8. Does the patient have a long-term health problem such as heart disease, kidney disease, metabolic disease (e.g., **diabetes**), or blood disorders (e.g., **anemia**)?	❑	❑
9. Does your child have a weakened immune system caused by cancer, cancer treatment (e.g., x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. steroids)?	❑	❑
10. Does the patient live with or have a close contact with anyone with a severely weakened immune system requiring care in a protected environment (such as a hospitalized family member receiving chemotherapy)?	❑	❑
11. Is the patient receiving aspirin or other aspirin-containing therapy?	❑	❑
12. Has your child received a MMR (measles/mumps/rubella), varicella (chickenpox), or the live intranasal seasonal influenza vaccine (LAIV) within the past 4 weeks?	❑	❑
13. Does the patient have a muscle or nerve disorder (such as cerebral palsy) that can lead to breathing or swallowing problems?	❑	❑
14. Is the patient pregnant or nursing?	❑	❑
15. Does the patient have a history of nosebleeds?	❑	❑

HEALTH DEPARTMENT USE ONLY

Screening form reviewed by: _____ **Date:** _____

Vaccinate with 2009 H1N1 influenza vaccine? ☐ **Nasal Mist** ☐ **Injectable** ☐ **No** **If no, reason:**_____

☐ **VIS given** **CI#** _____ **Encounter #** _____