

# 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 \_\_\_\_\_

## Circle One Answer for Each Question Below:

- 1) Race: Asian  
Native American/Alaska Native  
Black/African American  
White  
Other
- 2) Ethnicity: Hispanic Latino  
Not Hispanic/Latino
- 3) Preferred injection site: Left Deltoid  
Right Deltoid