Health & Community Services

Influenza Vaccine Screening & Consent

VFC Status Screening*
__Private Insurance __Uninsured __American Indian
__Medicaid __Underinsured __Alaska Native
***Required for children less than 19 years**

Seasonal Influenza Vaccine:
VIS 8/11/09 Lot #: _____

Dose#: _____ *IM*: _____

_____
Administered By *Date*

Recall *Yes* *No*

Name: (Last) (First) (Middle Initial)		Age	Male Female
Parent/Guardian:	Home Phone:	Other Phone:	
Birthdate:	Address:	City: Zip:	

Age of person to receive vaccine:

q Less than 6 months q 6 months - 23 months q 24 months - 35 months
q 3 years - 8 years q 9 years - 18 years q 19 years - 24 years
q 25 years – 49 years q 50 years - 64 years q 65 years and older

Please answer the following questions for the person receiving the vaccine.

	YES	NO	DON'T KNOW
1. Are you sick today with a fever over 101F?	..	..	..
2. Have you ever received the flu vaccine before?	..	..	..
3. Have you ever had a serious reaction to vaccinations?	..	..	..
4. Do you have a severe allergy to hen's eggs, gelatin, neomycin,or polymyxin B?	..	..	..
5. Are you taking antiviral medications?	..	..	..
6. Did you develop Guillain-Barré Syndrome following a previous dose of flu vaccine?	..	..	..
7. Are you pregnant now or planning to be pregnant?	..	..	..
8. Are there children in the home under 6 months of age?	..	..	..
9. Are you a health care or emergency services worker involved in direct patient care?	..	..	..
10. Do you have any of the following conditions? • Heart or breathing conditions like asthma or wheezing? • Diabetes, kidney or liver disease? • Blood conditions (e.g., Sickle Cell Anemia) • On chronic aspirin therapy • Cancer, leukemia, AIDS, or any immune system problem?			 .. ..
11. Do you reside in a nursing home or other care facility?	..	..	..

è "I have had read or had explained to me the information on the Vaccine Information Statement (VIS) of **8/11/09** and/or **10/02/09** about the influenza vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or to the person named for whom I am authorized to make this request."

Signature: _____ Date: _____
(Signature of person to receive vaccine or parent/guardian)

Your vaccination record will be kept in your medical file. It along with any collected historical immunization information may be entered into the CHILD Profile Immunization Registry that will be available to other medical providers in Washington State. The CHILD Profile Immunization Registry is a secure system and immunization information can only be seen by a doctor, nurse, or clinic that needs the information to provide medical care.

Medicare (attached) _____ **CASH** **CHECK#**_____

Medicaid (attached) _____ **Bill To:** _____

Receipt _____

Novel H1N1 Vaccine:
VIS 10/02/09 Lot #: _____

Dose#: _____ *IM*: _____

_____
Administered By *Date*

Recall *Yes* *No*