Hingham Health Department

H1N1 Influenza Vaccine Screening Questionnaire and Documentation Record

Last Name:	First Name:	Phone Number
Date of Birth:	Age:	Gender: ☐M ☐F

Street Address:	City/Town:	State	Zip

The following questions will help us determine if there is any reason you should not receive the influenza vaccine. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

Please circle answers to questions below.			
1. Is this the first flu vaccine that you have ever received?	Yes	No	Not Sure
2. Are you sick today?	Yes	No	Not Sure
3. Are you allergic to eggs or to a component of the influenza vaccine?	Yes	No	Not Sure
4. Have you ever had Guillain-Barré syndrome?	Yes	No	Not Sure
5. Have you ever had a serious reaction to a previous dose of influenza vaccine?	Yes	No	Not Sure
6 List any serious allergies: ______________________________			

Consent:

____

Signature of vaccine recipient or parent/legal guardian of a child under age 18

For Clinical / Office Use

☐ Illness Assessment

☐ Questionnaire Reviewed

Date on VIS: 10/02/09

Site: R Deltoid IM

Name/Title of vaccine administrator:

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Clinic/Office address :210 Central Street

Place Vaccine Label Here