

H1N1 Influenza Immunization Screening Form - Chief Leschi Schools

Name _____ Birth Date _____ Age _____ Male Female
(last) (first) (MI)

Address _____
(street) city state zip phone

Parent or Guardian (if under 18) _____
(last) (first) phone # where parent can be reached

Child's Grade _____ Name of Teacher or Homeroom _____

Please answer the following questions for the person receiving vaccine:	YES	NO	N/A
1. For children 9 and younger, is this the child's 1 st or 2 nd vaccination for H1N1? Circle one please.	1st	2nd	
2. Does the person to be vaccinated have a severe allergy to eggs (like trouble breathing)?			
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? If yes, which vaccine? _____			
4. Has the person to be vaccinated ever had Guillain-Barre syndrome (GBS- muscle weakness/paralysis) within 6 weeks of a flu vaccination?			
5. Is the person to be vaccinated pregnant? If yes, there is no need to answer the rest of the questions. PROCEED TO SIGNATURES.			
6. Is the person to be vaccinated younger than age 2 or age 50 or older? If yes, DO NOT COMPLETE SHADED PORTION. PROCEED TO SIGNATURES.			
7. Does the person to be vaccinated have asthma, reactive airway disease, or experience episodes of wheezing?			
8. Does the person to be vaccinated have any chronic medical conditions such as diabetes, heart disease, lung disease, kidney problems, blood diseases or immune system problems (like HIV, cancer, on chemotherapy, organ transplant)?			
9. Is the person to be vaccinated on aspirin for a chronic condition?			
10. Does the person to be vaccinated live with anyone with severe immune system problems?			
11. Has the person to be vaccinated had any vaccinations in the past 4 weeks? If so, what vaccines? List here _____			

I have received the Vaccine Information Statement(s) about the vaccines I (my child) will receive. I request that the vaccines be given. Depending on the answers to the screening questions and vaccine availability, I (my child) could receive a flu shot or a nasal spray vaccine. I understand that I do not have to be present for my child to receive the flu immunization.

Client Signature: _____ Date: _____

OFFICE USE ONLY

ASSESSMENT FOR VACCINE ELIGIBILITY

Questions 2-11= ALL NO → LAIV

Any answers 5-10= YES → Injectable

Question 11- live vaccine listed → Injectable

Questions 2-4 = YES → No vaccine or use w/ caution*

*Vaccine is contraindicated in persons with severe egg allergy (anaphylaxis) or severe reaction to flu vaccine or any flu vaccine component. Use with caution in persons w/ hx GBS.

Preservative Free Preferred (Pregnant or under age 3 years)

Preservative Free Not Available

Injectable Vaccine

Signature _____

Date _____

Manufacturer - _____

Lot#- _____

Exp _____

Dose 0.25ml (under age 3)

Dose- 0.5ml (age 3 & up, age 4 & up for Novartis product)

Site: L R Arm IM

VIS Date 10/2/09

Live Attenuated Vaccine

Signature _____

Date _____

Manufacturer - Medimmune

Lot#- _____

Exp _____

Site: Intranasal 0.2 ml

VIS Date 10/2/09