



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Male/Female \_\_\_\_\_ (mo.) (day) (yr.)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
 Patient Phone: \_\_\_\_\_ Primary Care Dr: \_\_\_\_\_

Insurance ID: \_\_\_\_\_ GRP: \_\_\_\_\_ BIN: \_\_\_\_\_ PCN: \_\_\_\_\_  
 Insurance Provider Phone: \_\_\_\_\_  
 Cardholder Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**IF NO INSURANCE, the discounted price for vaccine is \$15.00.**

## Screening Checklist for Contraindications to Inactivated Injectable Flu Vaccinations

### For adult patients as well as parents of children 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 vaccine today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain.

	Yes	No	Don't know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?			

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Location given: \_\_\_\_\_ Lot: \_\_\_\_\_ Exp: \_\_\_\_\_