Del Norte County Public Health

Screening Checklist for Contraindications to Influenza Vaccination

Please mark the answers to the following questions for the person who is receiving the flu vaccine. Parents or guardians should answer the questions on behalf of minors 0-17 years old.

PATIENT NAME: _____

ANY NICKNAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

MOTHER MAIDEN NAME: _____

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 the influenza vaccination today.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Previous allergy to a component of the vaccine?	☐	☐	☐
3. Previous serious reaction to the influenza vaccine?	☐	☐	☐
4. Does the person to be vaccinated have any long-term health issues, such as lung disease (including asthma), heart disease, kidney disease, neurologic disease, liver disease, or metabolic disease (including diabetes) or immunocompromised?	☐	☐	☐
5. Has the person to be vaccinated received a shingles, measles (MMR), or chicken pox vaccine in the last 4 weeks?	☐	☐	☐
6. Does the person to be vaccinated live with or expect to have close contact with someone with a severely weakened immune system?	☐	☐	☐
7. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

Your vaccination will be entered into our immunization database for inventory tracking and public health surveillance purposes. Please read the CAIR disclosure statement for more information. Please also review the Influenza Vaccine Information Statement and ask any questions you may have about the influenza vaccine.

FORM COMPLETED BY: _____ **DATE:** _____

FOR MEDICAL STAFF USE ONLY	
Clinic Site:	**Vaccine Type:** ☐ Inactive ☐ LAIV
Clinic Date:	**Lot Number:**
Nurse Initials:	**Expiration Date:**
Route and Site: ☐ Nasal ☐ Injected Left Arm ☐ Injected Right Arm ☐ Injected Other:	
FORM REVIEWED BY: _____ **DATE:** _____	