MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
INFLUENZA VACCINE PROGRAM	NAVHOSPPNCLAINST 6230.5	06 Sep 2016

LOCAL FORM TITLE *(Optional)*
ADULT SCREENING AND IMMUNIZATION DOCUMENTATION FOR INFLUENZA VACCINATION PROGRAM

The following questions will help us determine if we should give you the intranasal or the injectable influenza vaccination today. If you answer "yes" to any question, we will ask additional questions to determine which vaccine, if any, you will receive. Please speak to your healthcare provider if you have any questions.

What is your age? _____

	NO	YES
1. Do you currently feel sick or have a fever?	☐	☐
2. Are you taking any prescription medications to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	☐	☐
3. Are you pregnant or planning to become pregnant in the next 3 months?	☐	☐
4. Have you ever had a serious reaction to a flu vaccine?	☐	☐
5. Do you have any allergy to any of the following: eggs, chicken or egg protein, gentamycin, gelatin, arginine, neomycin, polymycin B, thimerosal, formaldehyde or other vaccine components?	☐	☐
6. Are you allergic to Latex or Latex products?	☐	☐
7. Do you have a chronic health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	☐	☐
8. Do you have an active neurological disease?	☐	☐
9. Do you have a history of Guillain-Barre Syndrome (GBS)?	☐	☐
10. Has your doctor ever told you that you have an immune system disorder? Are you taking long-term steroid treatment or immunosuppressants?	☐	☐
11. Do you have HIV, AIDS, cancer or have you received an organ transplant?	☐	☐
12. Do you live with or have close contact with severely immunocompromised individuals or someone who must be in a protective environment (such as transplant recipients)?	☐	☐
13. Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks?	☐	☐

Medication Reconciliation: If you are 49 years of age or younger, please list below all the medications you are currently taking.

I have read, or have had explained to me the information in the Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.

Signature: _____ Date: _____

(CONTINUE ON REVERSE SIDE)

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

TO BE COMPLETED BY HEALTHCARE PROVIDER

☐ Give injectable seasonal Influenza vaccine

☐ Do NOT administer seasonal Influenza vaccine

VIS provided (check box)

☐ Inactivated Influenza Vaccine (TIV)

Comments:

Interviewer's Signature:

Date:

VACCINE ADMINISTERED

☐ Inactivated Influenza (Afluria) Single dose syringe

Dose: 0.5 mL

Route: Intramuscular ☐ Right Deltoid ☐ Left Deltoid

Ages: 9 years old and greater

DOES NOT CONTAIN LATEX; DOES NOT CONTAIN THIMEROSAL

Lot # _____

Manufacturer: Seqirus

☐ Inactivated Influenza (FluArix)

Dose: 0.5 mL

Route: IM (check one) ☐ Right Deltoid ☐ Left Deltoid

Ages greater than 3 years old

DOES NOT CONTAIN LATEX

Lot # _____

Manufacturer: Glaxo Smith Kline

☐ Inactivated Influenza (FluLaval)

Dose: 0.5 mL

Route: IM (check one) ☐ Right Deltoid ☐ Left Deltoid

greater than or equal to 3 year olds

CONTAINS THIMEROSAL; DOES NOT CONTAIN LATEX

Lot # _____

Manufacturer: Glaxo Smith Kline

☐ Inactivated Influenza (Afluria) Multi dose Vial

Dose: 0.5 mL

Route: Intramuscular

Ages: 9 years old and greater

DOES NOT CONTAIN LATEX; CONTAINS THIMEROSAL

Lot # _____

Manufacturer: Seqirus

☐ Inactivated Influenza (Fluzone - High Dose)

Dose: 0.5 mL

Route: IM (check one) ☐ Right Deltoid ☐ Left Deltoid

Ages greater than 65 year olds

DOES NOT CONTAIN LATEX

Lot # _____

Manufacturer: Sanofi Pasteur

Administered by:

Date:

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
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