Patient ID________________ Date____________ Temp______C

Influenza Vaccine Questionnaire

The following questions will help us determine if we can safely vaccinate you today.

Please ask the doctor to explain anything that is not clear to you prior to the vaccination.

Name		Date of Birth	/ / (Mo. / Day / Yr)

	Yes	No	Don't know
1. Have you read the influenza vaccine information sheet?			
2. Do you have any allergies to medications or foods?			
3. Have you ever received an influenza vaccination?			
4. Have you ever had a severe reaction to any vaccine?			
5. Have you ever had any diseases of the nervous system including seizures?			
6. Do you currently have any illnesses? If yes, please list:			
7. Have you ever been diagnosed with an immune deficiency?			
8. Are you currently pregnant?			
9. Have you received any other vaccinations in the past 4 weeks?			
10. Are you feeling well today?			

I have read the information provided regarding the seasonal influenza vaccine and understand the risks and benefits of the vaccine planned for administration. My questions have been answered and I agree to the administration of the vaccine.

_________________________________ ____________________

Signature Date

FOR CLINIC USE ONLY:

VACCINATION DATE:	/ /		SITE:	RIGHT	ARM
LOT NUMBER.:				LEFT	LEG
VOLUME:	0.1 0.2 0.25 0.3 0.5		BY:		M.D. / R.N.