



Patient Name: _____ **Date of Birth:** _____

Screening Questionnaire for Intranasal Influenza Vaccination

The following questions will help us determine if there is any reason we should not give your child the intranasal influenza vaccine (Flu Mist) today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It simply means additional questions must be asked. If a question is not clear, please ask our clinical staff to explain it.

	Yes	No	Unknown
1. Is the person being vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to the intranasal influenza vaccine (Flu Mist) in the past?			
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?			
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (ex: diabetes), anemia, or other blood disorders?			
6. If the person to be vaccinated is a child 2 through 4 years of age, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?			
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?			
8. Is the person to be vaccinated receiving aspirin therapy or aspirin containing therapy?			
9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?			
10. Has the person to be vaccinated ever had Guillain-Barré syndrome?			
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?			
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?			

Form completed by:(Please Print) _____

Signature: _____ Date: _____

Office Use Only

Reviewed by: _____ Date: _____