# 2015-2016 CHILDREN/ADOLESCENT SEASONAL INFLUENZA VACCINATION PROGRAM

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| 1 | Name (Please Print) | Date of Birth | Sponsor's Full SSN |
|---|---|---|---|
| | _____, _____, _____<br>Last First MI | _____, _____, _____<br>DD MMM YYYY | __ __ __ - __ __ - __ __ __ __ |

| 2 | CHILDREN & ADOLESCENT SCREENING AND IMMUNIZATION WORKSHEET<br>6 Months to Under 18 Years of Age | | |
|---|---|---|---|
| 1 | Is your child under 9? | ☐ NO | ☐ YES |
| 2 | Has your child received fewer than two flu vaccine doses since July 2010? | ☐ NO | ☐ YES |
| 3 | Does your child currently feel sick or have a fever? | ☐ NO | ☐ YES |
| 4 | Has your child ever had a serious reaction to a flu vaccine in the past? | ☐ NO | ☐ YES |
| 5 | Does your child have a history of Guillain-Barre Syndrome (GBS)? | ☐ NO | ☐ YES |
| 6 | Does your child have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, thimerosal, formaldehyde, or other vaccine components? | ☐ NO | ☐ YES |
| 7 | Is your child younger than 2 years of age? | ☐ NO | ☐ YES |
| 8 | Does your child have a history of asthma, reactive airway disease, or wheezing? | ☐ NO | ☐ YES |
| 9 | Does your child have heart disease, lung disease, kidney disease, neurological disease, metabolic disease (e.g., diabetes), a blood disorders or any other chronic health conditions? | ☐ NO | ☐ YES |
| 10 | Does your child have a weakened immune system because of HIV or another disease that affects the immune system; take long-term high-dose steroid treatments, or cancer treatment with radiation or Drugs? | ☐ NO | ☐ YES |
| 11 | Is your child taking aspirin or aspirin-containing products? | ☐ NO | ☐ YES |
| 12 | Is your child taking any prescription medicines to prevent or treat influenza? Have they taken any antivirals in the last 48 hours? | ☐ NO | ☐ YES |
| 13 | Does your child live with or expect to have close contact with severely immunocompromised individuals who must be in a protective environment (such as transplant recipients?) | ☐ NO | ☐ YES |
| 14 | Is the adolescent to be vaccinated pregnant? | ☐ NO | ☐ YES |
| 15 | Has your child received any vaccines within the last 30 days or are they going to receive any additional vaccines within the next 4 weeks? | ☐ NO | ☐ YES |
| *** | **I have been offered an Influenza Vaccine Information Statement (VIS).** | ☐ NO | ☐ YES |

*********STOP HERE*********

***TO BE COMPLETED BY HEALTHCARE STAFF*** DATE: _____

☐ **GIVE INTRANASAL**

☐ FluMist, MedImmune (2 to 49 years)

**Lot#**_____

**Dose:** 0.2 ml (0.1 ml each nostril)

**Route:** Intranasal

☐ Recommended 2nd dose after 30 days

☐ **GIVE INJECTABLE**

☐ **FLUZONE PEDS**, (6 months to 35 months)

☐ **FLULAVAL**, (3 years & older)

☐ **FLUVIRIN**, (4 years & older)

☐ **AFLURIA**, (9 years & older)

**Lot#**_____

**Dose:** 0.25 ml 0.5 ml

**Route:** IM

(6-12 mo) Thigh Left Right

( >12 mo ) Deltoid Left Right

| SCREENED BY: | ADMINISTERED BY: |
|---|---|
| | |

***THIS FORM WILL BE DESTROYED upon completion of electronic entry (AHLTA, MEDPROS, etc.)**