

Pediatric/Adolescent Screening and Immunization Worksheet 2013-2014 Seasonal Influenza Vaccination Program

The following questions will help us determine if we should give your child 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, your child will receive. Please speak to your healthcare provider, if you have any questions.

Circle answers to questions 1-15:

1	Is your child under 9?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2	Has your child received fewer than two flu vaccine doses since July 2010?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3	Does your child currently feel sick or have a fever?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4	Has your child ever had a serious reaction to a flu vaccine in the past?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5	Does your child have a history of Guillain-Barre Syndrome (GBS)?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7	Is your child younger than 2 years of age?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
8	Does your child have a history of asthma, reactive airway disease, or wheezing?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
11	Is your child taking aspirin or aspirin-containing products?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
12	Is your child taking any prescription medicines to prevent or treat influenza? Have they taken any antivirals in the last 48 hours?	<input type="checkbox"/> No	<input type="checkbox"/> 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?)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
14	Is the adolescent to be vaccinated pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

"I have read or have had explained to me the information in the 2013-2014 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: _____

***** Please complete the bottom left box ***** otherwise to be completed by healthcare staff

- Give injectable flu vaccine today
- Give intranasal flu vaccine today
- Do not administer flu vaccine today

Interviewer's Signature

Date

Vaccine administered

- Live Intranasal Influenza – 2 to 49 yrs (FluMist, MedImmune)
Lot # _____
Dose: 0.2 ml Route: Intranasal
- Inactivated Influenza - 6 mo and older (Fluzone, Sanofi-Pasteur)
- Inactivated Influenza – 4 yrs and older (Fluvirin, Novartis)
- Inactivated Influenza – 9 yrs and older (Afluria, CSL)
Lot # _____

Injectable description – continued

Dose (6-35 mo): 0.25mL

Route: IM (6-12mo) Thigh L / R

IM (>12mo) Deltoid L / R

Dose (≥36mo): 0.5mL

Route: IM Deltoid L / R

Child's Name:

Child's DOB:

Sponsor's SSN:

Administered by:

Date