Patient Name ______________________________ Date of Birth_____/_____/_____
(mo.) (day) (yr.)

Doctor/Clinic Name ________________ Doctor Address ______________________________

Screening Questionnaire for Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

Form Completed By ______________________________ Date ______________

Form Reviewed By ______________________________ Date ______________
Kemper Drug, 323 Jackson Ave, Elk River, Mn 55330

Vaccine Lot#______________

Vaccine Expiration Date______________

Insurance Information ☐ Paid Cash ☐ Bill to Insurance

Cardholder Name ____________________ Cardholder Birthdate ______________

Address ______________________________Phone Number ______________

Insurance Company Name______________________________

Id Number____________________ Group Number ______________

☐ (Photocopy of Insurance Card Attached)

☐ Received VIS for Inactivated Influenza Vaccine (8/11/09)

Technical content reviewed by the Centers for Disease Control and Prevention, September 2009.