Name: Last_____ First_____ M.I. _____

Date of Birth: _____

CNHS Influenza Vaccination Pre-Screening and Administration Tool

			Comment
Is the person to be vaccinated sick today?	Yes	No	
Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	Yes	No	
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes	No	
Has the person to be vaccinated ever had Guillain-Barré syndrome?	Yes	No	
Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	Yes	No	
Is the person to be vaccinated anxious about getting a shot today?	Yes	No	

Patient/Parent/Guardian's Printed Name: _____

Patient/Parent/Guardian's Signature: _____ Date: _____

Vaccinator Use Only, Do Not Mark Below This Line:

Name: _____ Date of Birth: _____ MRN: _____	NKDA / Allergies:
Given by: _____	Date of Injection: _____ Time of Injection: _____
Age Range: 6-35 months / 36+ months / 65+ years	Lot #: _____ Expiration: _____
Manufacturer: _____	Injection Site: LEFT Deltoid / RIGHT Deltoid