County of Orange Health Care Agency

Influenza Vaccination Questionnaire

*Please fill out **one form for each person** who will be receiving a flu shot. Your answers are anonymous.*

Use a **blue** or **black** pen only. Please Print Clearly. Examples: ● A B C

I have read, or had explained to me, the "Influenza Vaccine Information Statement." I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and request that it be given to me or to the person for whom I am completing this form and for whom I am authorized to make this request.

Today's Date: M M / D D / Y Y **Signature:**

Relationship if patient is under 18 years of age:

General Information About Person Receiving Vaccine

1) What is the ZIP code of where you live?

2) Primary Language Spoken: (fill in **ONE** circle)

○ English ○ Spanish ○ Vietnamese ○ Other (please list):

3) Race/Ethnicity: (fill in **ONE** circle) *If more than one race/ethnicity, please fill in "Multiple Race"*

○ White ○ Hispanic ○ Asian ○ Black ○ American Indian/Alaskan Native

○ Multiple Race ○ Other (please list):

4) Gender: ○ Male ○ Female

Screening Information About Person Receiving Vaccine

1) How old are you? (fill in **ONE** circle)

○ 6-23 months ○ 24-35 months ○ 3-4 yrs ○ 5-8 yrs ○ 9-18 yrs

○ 19-49 yrs ○ 50-59 yrs ○ 60-64 yrs ○ 65+ yrs

***NOTE:** If age selected is from 6 months to 8 years, please provide 2nd Dose referral form.*

	Yes	No
2) Are you feeling sick today or have a fever above 100ºF degrees?	○	○
3) Are you allergic to eggs or another component of influenza vaccine?	○	○
4) Have you previously had a serious reaction to the influenza vaccine?	○	○
5) Have you ever had Guillain Barre Syndrome?	○	○
6) Have you received an influenza vaccination since August?	○	○

*(If **YES** has been selected for questions 2 - 6, please remove from line and refer to Clinic Branch Director and/or Medical Branch Director for further evaluation/referral.)*

7) **WOMEN ONLY**: Are you pregnant or planning to be within the next month? ○ ○

*(If **YES** has been selected for question above, provide only preservative free, single dose vaccination.)*

Office Use Only

Vaccine Type Administered: ○ Single Dose ○ Multidose ○ **Did Not Vaccinate- Referral Provided**

Manufacturer: Lot Number:

Signature, Name and Title of Vaccinator:

Nursing Instructor Co-sign (if applicable):

Signature of Interpreter (if applicable):

POD Site Location: A

E

1 2 3 4 5 6 1 1 5 4 5 4 7