University Health & Counseling Service Immunization Record Form

Influenza Vaccine

Student/ Emp ID#_____

Patient Name (Last, First)**:** _____ **Date of Birth:** ___/___/_____

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES FOR ADULTS

For Patients: The following questions will help us determine which vaccines you may be given today. If you answer 'yes' to any question, it does not necessarily mean you 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.

1. Are you sick today?	Yes	No	Don't Know
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No	Don't Know
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No	Don't Know
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	Yes	No	Don't Know
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No	Don't Know
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No	Don't Know
7. Have you had a seizure or a brain or other nervous system problem?	Yes	No	Don't Know
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No	Don't Know
9. **For women:** Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No	Don't Know
10. Have you received any vaccinations in the past 4 weeks?	Yes	No	Don't Know

I have received a copy of the CDC Vaccine Information Sheet and I have had an opportunity to ask questions prior to receiving the immunization.

Patient Signature: _____ Date: _____

Vaccine Administrator's Name_____

PLEASE PLACE THIS COPY IN "TO BE SCANNED" FOLDER