FLU

# Colorado Influenza Vaccine
# Vaccine Screening and Administration Form

*Please print neatly in capital letters as shown in the example:*

EXAMPLE 123

*Please answer all questions as completely as possible.*
*Please use only black ink to complete form.*

*The administration record is on the reverse side of this document.*
*You will receive a record of the vaccination to take home with you.*

**Please complete ALL the information below as accurately as possible. If you are completing this form for your minor child, do not use nick-names or abbreviations, except where allowed. All information is confidential.**

Last Name | First Name | M.I.

Date of Birth (M M / D D / Y Y Y Y) | Age: (years) | (months) (If less than 4 years old) | Patient/Representative Daytime Phone Number

If under 18 years of age please complete: Parent First Name | Parent Last Name

Address | Apt. Number

City | County | State

Zip Code | E-mail Address

Gender Identity ☐ F ☐ M ☐ Transgender Female/Feminine ☐ Transgender Male/Masculine ☐ Non-Binary ☐ Un-specified ☐ Decline to Provide

**Ethnicity** (please check one)
Hispanic/Latin/a/o/x
Y ☐ N ☐ Decline to Provide ☐

**Race(s) check all that apply**
☐ American Indian/Alaskan Native
☐ Asian
☐ Black, African American
☐ Native Hawaiian/Pacific Islander
☐ Other
☐ White
☐ Decline to Provide

## NOT REQUIRED

If your child is between ages 6 months and 9 years of age, please answer the following: Has your child ever had a total of 2 doses of flu vaccine? Y ☐ N ☐ Don't know ☐

| | Health Screening Questions | Yes | No |
|---|---|---|---|
| 1. | Are you or your child sick today or have a fever? | | |
| 2. | Have you or your child ever had a serious allergic reaction (anaphylaxis) to flu vaccine or any ingredients like gelatin, antibiotics, or other ingredients? | | |
| 3. | Have you or your child ever had Guillain-Barré Syndrome within 6 weeks after getting a flu shot (a type of temporary severe muscle weakness)? (Should not get nasal spray flu vaccine.) | | |
| 4. | Are you or your female teen pregnant or planning to become pregnant in the next 2 months? (Pregnant individuals should not get nasal spray flu vaccine.) | | |
| 5. | Are you or your child receiving aspirin-or-salicylate-containing medicines? (Should not get nasal spray flu vaccine.) | | |
| 6. | Do you or your child have a weakened immune system? (Should not get nasal spray flu vaccine.) | | |
| 7. | Is your child younger than age 2 years? (Should not get nasal spray flu vaccine.) | | |
| 8. | Does your child age 2 through 4 years have asthma or a history of wheezing in the past 12 months? (Should not get nasal flu vaccine.) | | |
| 9. | Do you or your child have a medical condition like diabetes or heart disease? (Should not get nasal flu vaccine.) | | |
| 10. | Do you or your child have cochlear implant(s) or have a cerebrospinal fluid leak? (Should not get nasal flu vaccine.) | | |
| 11. | Is your child 5 years or older and has asthma? (Should not get nasal flu vaccine.) | | |
| 12. | Are your or your child around anyone that is severely immunocompromised (someone that requires a protected environment)? (Should not get nasal flu vaccine.) | | |
| 13. | Are you over 49 years of age? (Should not get nasal flu vaccine.) | | |
| 14. | Are you over age 65? | | |



Continued on Next Page

Last Name

First Name

Date of Birth M M / D D / Y Y Y Y

For children betweenages 6 months and 9 years:

Dose Number: 1 ☐ 2 ☐

## Authorization to Administer Influenza Vaccine

I have read or had explained to me the Vaccine Information Sheet for the Influenza Vaccine that I and/or my child will receive. I understand the benefits and risks of receiving this vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Signature of Patient/Parent/Legal Guardian/Medical Power of Attorney: _____ Date: _____/_____/_____

Parent First Name

Parent Last Name

## STOP: DO NOT WRITE BELOW THIS LINE-FOR CLINIC STAFF ONLY

VFC PIN: 7434

Provider Type: ☒ Public ☐ Private

Clinic Name: MVU-5

Provider Name

**Manufacturer**

☐ GSK ☐ Seqirus
☐ ID BioMed ☐ PSC
☐ PMC (Sanofi) ☐ MedImmune, Inc

Brand Name

Lot Number

**Dosage**

☐ 0.25 ml ☐ 0.7 ml
☐ 0.5 ml ☐ 0.2ml (0.1ml/nostril)

**Site**

☐ LD ☐ LT
☐ RD ☐ RT
☐ Nasal

**VIS Publication Date**

IIV _____/_____/_____

LAIV _____/_____/_____

Date Administered M M / D D / Y Y Y Y

Administered by:

Name _____ Title _____