



# 2013 - 2014 Insurance Information Form

## Stow Board of Health/Medical Reserve Corps Flu Clinic 2013-2014

### SCREENING QUESTIONNAIRE FOR INFLUENZA VACCINATION.

(Please circle yes or no)

- |  |     |    |                   |
|--|-----|----|-------------------|
| 1. Are you 18 years or older?  | Yes | No | (if no) Age: ____ |
| 2. Have you have a flu shot before?  | Yes | No |                   |
| 3. Have you ever had a severe reaction to any vaccine?                     | Yes | No |                   |
| 4. Do you have any fever, diarrhea or vomiting today?                      | Yes | No |                   |
| 5. Are you allergic to:  |     |    |                   |
| - Eggs or egg products,  | Yes | No |                   |
| -Thimerosal (a preservative in some vaccines and<br>contact lens cleaners) | Yes | No |                   |
| - Latex, other? Please list _____  |     |    |                   |
| 6. Have you had Guillain-Barre syndrome?                                   | Yes | No |                   |
| 7. Are you taking any blood-thinning medications?                          | Yes | No |                   |

**Note:** Answering yes to questions above, may warrant referral or consultation with a medical provider for further evaluation, to determine appropriateness of vaccination today.

### INFORMED CONSENT

I have read the information on the Vaccine Information Sheet (VIS- 7/26/2013) by the Center for Disease Control about influenza and influenza vaccine. I have had the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me.

Date: \_\_\_\_\_

**Signature** of person receiving vaccine (parent or guardian if under 18 yrs)

Name: \_\_\_\_\_ **(Print)**

Name: \_\_\_\_\_ **(Signature)**