CNHS Influenza Vaccination Pre-Screening Tool

Name: Last_____ First_____ M.I. _____

Date of Birth: _____

			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	

Patient/Parent/Guardian's Printed Name: _____

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