

HEALTH RECORD Rev: 1 SEP 11	CHRONOLOGICAL RECORD OF MEDICAL CARE/SF600 SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION
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FLU VACCINE SCREENING AND CONSENT FORM (Please Print Clearly)

Last Name, First:	DOB:
Prefix & Sponsor's Full SSN:	Age:
Status (Circle): AD / Civilian / Healthcare Worker / MID /Retired	Company (for MIDS only): _____
Date: _____ Time: _____	

The Influenza Vaccine Information Statement dated July 2011 was available for review.

I consent to receiving the vaccine. Patient/Guardian's Signature: _____

Patients: Please circle &/or answer the questions #1-14 below:

1 Do you have an allergy to eggs, chicken, gelatin, thimerosal, or neomycin? What? _____	YES	NO
2 Have you ever required medical care because of a reaction to a previous immunization?	YES	NO
3 Have you ever had Guillain-Barre Syndrome (a severe paralytic illness, also called GBS)?	YES	NO
4 At this time, do you have a fever or are you moderately to severely ill?	YES	NO
5 Are you currently taking aspirin?	YES	NO
6 Do you have a weakened immune system or immune disorder (AIDS, HIV, cancer)?	YES	NO
7 Are you in close contact with severely immunocompromised individuals (ie. transplants)?	YES	NO
8 Do you have a history of wheezing, reactive airway disease, asthma or lung disease?	YES	NO
9 Do you have heart, kidney or metabolic diseases (diabetes), anemia or other blood disorders?	YES	NO
10 Are you currently pregnant/breastfeeding or plan to become pregnant within the next month?	YES	NO
11 Have you received any vaccines within the past month? What _____	YES	NO
12 Have you been on any prescribed medication for the flu in the last 48 Hours?	YES	NO
13 Do you receive healthcare from the Johns Hopkins Family Health Plan?	YES	NO
14 Please list any medications you are currently taking: _____		

Immunization Staff to complete below by circling appropriate answer:

	Correct	Incorrect
1. Patient has no contraindication to the flu vaccine. The VIS was available in the clinic for review.	YES	NO
2. Patient's medications were reconciled prior to getting the influenza vaccine.	YES	NO
3. Influenza vaccine administered to patient.	YES	NO
4. Patient instructed to wait in clinic 15 minutes to monitor for reaction (30 min for egg allergy patients)	YES	NO
5. Patient instructed to return to clinic in 1 month to receive 2nd dose if required.	YES	NO

FOR EGG ALLERGY PATIENTS ONLY (VACCINE MUST BE ADMISTERED BY RN OR PROVIDER)

Patient reports allergy to egg but is able to eat them or has mild symptoms such as hives. Patient denies systemic symptoms.

Patient would like to get flu vaccine in clinic. Patient instructed to wait 30 minutes in clinic after vaccinations.

Patient instructed that this is a BLS clinic and all reactions will need to be transported via ambulance to closest ER.

Pt Signature _____

FluZone (Split)	FluZone (NOS)	Afluria	MedImmune (Live Intranasal)
6 months - 35 months	3 years & up	9 years & up	2 yrs-49 yrs
Dose: 0.25 ml	Dose: 0.5 ml	Dose: 0.5 ml	Dose: 0.2 ml (0.1 ml in ea. nostril)
Dose #: 1 / 2	Dose #: 1 / 2	Site: RA / LA	Dose #: 1 / 2
RT / LT / RA / LA	RT / LT / RA / LA	Lot # N56606	Site: R&L Nares
Lot # UT4176BA	Lot # UT424AA		Lot # 501117P
Staff Name/Signature: _____			Date: _____

Imms. Module

Coded

Medical Records