

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT <i>(Title and Number)</i> NAVHLTHCLHINOTE 6230	ISSUANCE DATE 15 Sep 2016
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LOCAL FORM TITLE *(Optional)*
INFLUENZA IMMUNIZATION SCREENING AND CONSENT

LAST NAME (please print): _____ FIRST NAME (please print): _____ AGE: _____

Please answer ALL questions with "YES" or "NO", then sign and date.

	YES	NO
1. Do you currently feel sick or have a fever?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any allergy to any of the following: (circle) eggs, chicken or egg protein, gentamycin, neomycin, polymyxin, thimerosal, formaldehyde or other vaccine components?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
5. CHILDREN UNDER 8 YRS: Has your child received two or more flu vaccines in his/her life?	<input type="checkbox"/>	<input type="checkbox"/>

6. CHILDREN: If your child is receiving the vaccine today, how old is your child? _____ years _____ months

I have read the above information and have truthfully answered all the questions on this form. I have received or have had explained to me the information in the appropriate Vaccine Information Sheet(s) (VIS). I have had the chance to ask questions, fully understanding the benefits and risk, and give consent to authorized staff to administer the influenza vaccine to me or my child.

Patient or Parent/Guardian Signature: _____ Date: _____

Category: AD GS CONT RET DEP VOL STU OTH

Service (AD only): Navy Army AF MC CG

(continue on reverse side)

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)</i>	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

MEDICAL STAFF USE ONLY

AHLTA Encounter and Immunizations Module Update:

Initials: _____ Date: _____

Immunizations Tracking System Update:

Initials: _____ Date: _____

Vaccine Administered (CHECK ONE):

- FLUZONE 6mos to 35 mos (Pre-Filled - IM)
- FLULAVAL 3y and up (Vial - IM)
- FLUARIX 3y and up (Pre-Filled - IM)
- AFLURIA 9y and up (Pre-Filled - IM)

Lot #: _____

Manufacturer: _____

IM Site (CHECK): L R Deltoid Thigh

MEDICALLY INELIGIBLE FOR FLU VACCINE? YES If yes, PCM NAME: _____

Screener Name (please print) : _____

Vaccinator Name (please print) : _____

Vaccinator Signature: _____ Date: _____

PRACTITIONER'S NAME		PRACTITIONER'S SIGNATURE		DATE
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle, SSN, Sex, Date of Birth; Rank/Grade.)</i>		HOSPITAL OR MEDICAL FACILITY		STATUS
		DEPARTMENT / SERVICE	RECORDS MAINTAINED AT	
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