

MEDICAL RECORD REPORT

Naval Health Clinic Patuxent River & Branch Health Clinics Dependent, Retiree, Eligible Beneficiary Screening/Consent and Immunization Documentation Form 2010-2011 Influenza Vaccination Program

Full Name: _____ Sponsors Full SSN: Last First MI FMP: ____ / ____ - ____ - ____ Age: ____ DOB: ____	Please Check all that Apply: Family Member: <input type="checkbox"/> Retiree: <input type="checkbox"/> Civilian: <input type="checkbox"/> Other: <input type="checkbox"/> ____
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The following questions will help us determine if there is any reason we should not give you the intranasal or the injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Check the Yes or No Box to answer questions 1-14:		No	Yes
1.	Have you ever had a serious reaction to a previous Flu shot?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you currently have a respiratory illness or a fever?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Are you allergic to eggs, egg protein, or chicken protein?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have an allergy to neomycin, polymyxin, gentamicin, gelatin, or arginine?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have a history of Guillain-Barre Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you have an active neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Are you 50 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has your doctor ever told you that you have an immune system disorder or are you taking long-term steroid treatment?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you have HIV, AIDS, cancer, or have you received an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Are you pregnant or planning to become pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Are you taking any prescription medicines to prevent or treat influenza?	<input type="checkbox"/>	<input type="checkbox"/>
14.	For Pediatric Parents Only: Is your child currently taking aspirin?	<input type="checkbox"/>	<input type="checkbox"/>

I have received/read the Vaccine Information Sheet (VIS)* pertaining to the 2009-2010 influenza vaccine and none of the special precautions or contraindications pertain to me. I have had the opportunity to ask questions, and they were answered to my satisfaction.
 I have weighed the benefits and risks of receiving this vaccine and hereby consent to receiving the vaccine and request that the influenza vaccine be administered to me.

EXPLANATIONS

<input type="checkbox"/> HISTORY AND PHYSICAL EXAMINATION (SF 504, SF 505, SF 506)	<input type="checkbox"/> OPERATION REPORT (SF 516)	DATE DICT	
<input type="checkbox"/> CONSULTATION SHEET (SF 513)	<input type="checkbox"/> NARRATIVE SUMMARY (SF 502)		
<input checked="" type="checkbox"/> CHRONOLOGICAL RECORD OF MEDICAL CARE (SF 600)	<input type="checkbox"/> AUTOPSY PROTOCOL (SF 503)	DATE TYPED	
<input type="checkbox"/> PROGRESS NOTE (SF 509)	<input type="checkbox"/> OTHER:		
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	
DEPART./ SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name- last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.

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Signature of person to receive vaccine/parent if under age

Date

Below to be complete by healthcare provider

<input type="checkbox"/> Give injectable Flu vaccine today <input type="checkbox"/> Give intranasal FluMist today <input type="checkbox"/> Do not administer Flu vaccine today	Vaccine Information Statement Given <input type="checkbox"/>
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Interviewer's Signature	Date
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Vaccine Administered:

<input type="checkbox"/> FluMist 0.1mL per nostril (Lot # here) <input type="checkbox"/> FLUZONE 0.5mL IM Deltoid <input type="checkbox"/> R arm <input type="checkbox"/> L arm (Lot#here) <input type="checkbox"/> Pediatric FLUZONE 0.25mL IM Thigh <input type="checkbox"/> R Thigh <input type="checkbox"/> L Thigh (Lot#here) <input type="checkbox"/> Pregnancy/Breastfeeding FLUZONE 0.5mL IM Deltoid <input type="checkbox"/> R arm <input type="checkbox"/> L arm (Lot#here) <input type="checkbox"/> Contraindicated, Not Given	Administered by: _____ DATE
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EXPLANATIONS

<input type="checkbox"/> HISTORY AND PHYSICAL EXAMINATION (SF 504, SF 505, SF 506)	<input type="checkbox"/> OPERATION REPORT (SF 516)	<input type="checkbox"/> DATE DICT
<input type="checkbox"/> CONSULTATION SHEET (SF 513)	<input type="checkbox"/> NARRATIVE SUMMARY (SF 502)	
<input checked="" type="checkbox"/> CHRONOLOGICAL RECORD OF MEDICAL CARE (SF 600)	<input type="checkbox"/> AUTOPSY PROTOCOL (SF 503)	<input type="checkbox"/> DATE TYPED
<input type="checkbox"/> PROGRESS NOTE (SF 509)	<input type="checkbox"/> OTHER:	
RELATIONSHIP TO SPONSOR	SPONSOR'S NAME	
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