HEALTH RECORD CHRONOLOGICAL RECORD OF MEDICAL CARE DATE: _____

INFLUENZA VACCINE SCREENING FORM 2008-09

1- Is this the person's first **or** second time ever receiving the influenza vaccine **and** age 8 or younger?	YES NO
2- Does the person to be vaccinated have an allergy to eggs, or a component of the influenza vaccine (MSG, Arginine,Gentamicin, or Gelatin)?	YES NO
3- Has the person to be vaccinated ever had a serious reaction to intranasal (Flumist ®) or injectable influenza vaccine in the past?	YES NO
4- Has the person to be vaccinated ever had Guillian-Barré Syndrome?	YES NO
5- Is the person to be vaccinated severely ill today or do they have a nasal condition such as a very stuffy nose?	YES NO
6- Is the person to be vaccinated younger than 6 months?	YES NO
7- Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?	YES NO
8- Does the person to be vaccinate have a long-term health problem with heart disease, lung disease, asthma, kidney or liver disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?	YES NO
9- Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	YES NO
10- Is the person to be vaccinated pregnant or could become pregnant within the next 3 months?	YES NO
11- Has the person to be vaccinated received any other vaccination in the past 4 weeks?	YES NO
12- Is the person to be vaccinated age 2 through 4 years old with a history of recurrent wheezing?	YES NO
13- Is the person to be vaccinated younger than 2 or older than 49 years old?	YES NO
14- Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow?)	YES NO
15- I have read or had explained to me the information in the 2008-09 Vaccine Information Sheet.	YES NO
16- I have had a chance to ask questions and they have been answered to my satisfaction.	YES NO

17- How old is your child? _____

Fluzone 6months-35months	**Flumist (LAIV) 2years - 49years**
MFG: **Sanofi Pasteur** Dose: **.25ml** Lot #:_____ EXP._____ Route: IM SITE:**LT/RT** VIS: 7/24/08	MFG: **Medimmune** Dose: **.2ml** Lot#:_____ EXP:_____ Route: Intranasal VIS: 7/24/08
Fluzone 36months-18 years	**Afluria 18 years and up/ pregnant women**
MFG: **Sanofi Pasteur** Dose: **.5ml** Lot #:_____ EXP:_____ Route: IM SITE: **LD/RD** VIS: 7/24/08	MFG:**CSLBiotherapies** Dose: **.5ml** Lot#_____ EXP:_____ Route: IM SITE: **LD/RD** VIS: 7/24/08

Patient/Parent Signature Medical Screener

_____ _____

RECORDS MAINTAINED AT:	**USNH YOKOSUKA, JAPAN**	
PATIENT'S NAME (*Last, First, Middle Initial*)		SEX: **MALE / FEMALE**
RELATIONSHIP TO SPONSOR **Self / Spouse / Son / Daughter / Other: _____**	STATUS OF SPONSOR **AD / RET / CIV / GS / _____**	RANK/GRADE
SPONSOR'S NAME	ACTIVITY/DIVISION	
DEPT./SERVICE **DOD/**	SPONSOR'S SSN/IDENTIFICATION NO. **(30/123-45-6789)**	DATE OF BIRTH