LORAIN COUNTY PUBLIC HEALTH INFLUENZA VACCINE ADMINISTRATION

Client Name:	(Last) (First) (MI)			**Phone:**	( ) -
Address:	(Street) (City) (State) (Zip)				
☐ Male ☐ Female		**Date of Birth:**	/ /	**Age:**	**Township, if applicable:**

How did you hear about this flu clinic? (check all that apply)

☐ **Newspaper** ☐ **Radio** ☐ **Website** ☐ **School/Work** ☐ **Family/Friend** ☐ **Facebook/Twitter** ☐ **Other:**

LCPH participates in the Ohio Immunization Registry - Impact-SIIS. A confidential record of your flu shot will be entered in Impact-SIIS and LCPH's electronic health record system. The record includes your name, birth date, type of flu vaccine and the date given.

I have read or had read to me the flu Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction and am requesting the administration of the influenza vaccine.

I understand I may request a copy of the Lorain County Public Health (LCPH) Privacy Policy.

I authorize LCPH to share information to the identified insurance carrier(s) if payment for the flu vaccine is requested.

Signature: _____

(Parent or guardian's signature if client is under 18 years of age

Print Name: _____ **Date:**_____

Screening questions for both NASAL flu vaccine and INJECTABLE flu vaccine

Answer the following questions FOR THE PERSON BEING VACCINATED:

	YES	NO	UNSURE
1. Are you sick today?	☐	☐	☐
2. Are you allergic to a component in the vaccine?	☐	☐	☐
3. Have you had a serious reaction to the flu vaccine in the past?	☐	☐	☐
4. Are you younger than 2 years of age or older than 49 years of age?	☐	☐	☐
5. Do you have a long term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (like diabetes)?	☐	☐	☐
6. If you are a child between age 2 and age 4 years, have you been told in the last 12 months that you have wheezing or asthma?	☐	☐	☐
7. Do you have: a cochlear implant, spinal fluid leak, or no spleen; have cancer, leukemia, HIV/ AIDS, any immune system problem; in the past 3 months have you taken medication that affects the immune system such as prednisone or steroids, medications for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or other anticancer drugs; have you had radiation treatment?	☐	☐	☐
8. Are you receiving influenza antiviral medications?	☐	☐	☐
9. Are you between 6 months of age and 17 years old and are taking aspirin or salicylate containing medicine?	☐	☐	☐
10. Are you pregnant or could become pregnant within the next month?	☐	☐	☐
11. Have you had Guillain-Barré syndrome?	☐	☐	☐
12. Do you live with a person or have close contact with a person who must be in protective isolation (isolation room of bone marrow unit)?	☐	☐	☐
13. Have you received any other vaccines in the past 4 weeks?	☐	☐	☐

14. What type(s) of insurance do you have?
☐Medicare ☐Medicaid ☐Private insurance ☐No insurance

Form Completed by: _____ Date _____

Reviewed by: _____ Date _____

FOR NURSING USE ONLY					
Vaccine Lot # and Expiration Date:					
Site/Route (circle one):	**RD/IM**	**LD/IM**	**RVL/IM**	**LVL/IM**	**Nasal**
Influenza VIS (8/15/2019) given: ☐					
Signature of Vaccine Administrator:				**Date:**	