

This questionnaire must be completed along with the consent form prior to students receiving the H1N1 vaccine. If you have already sent the permission slip back then please just return this form to your Childs campus. If you have not yet returned the permission slip please fill out both forms (Consent & Questionnaire) and return both forms.

Both forms **MUST** be completed for the shot to be given.

### Screening questionnaire for Injectable 2009 H1N1 Influenza Vaccine

1. Have you read the vaccine information statement(s) for the vaccine(s) you plan to receive today?

YES NO

If YES, "Do you have any questions"? If NO, "Please take a few moments to read it / them now"

2. Is the person to be vaccinated moderately or severely ill today?

YES NO (Proceed to question #3)

If YES, please describe the illness. (Mild illness, such as colds or seasonal allergies, even if accompanied by a low-grade fever, is not a contraindication to vaccination. Vaccination should always be delayed if illness is moderate to severe).

3. Is this person to be vaccinated had a serious reaction after receiving a vaccination?

YES NO

If YES, please describe the vaccine involved and the reaction. (Anaphylactic reaction to any vaccine contraindicates further doses of that vaccine).

4. Is the person to be vaccinated ever been paralyzed with Guillain-Barre syndrome (an illness with sudden muscle weakness and some loss of senses in the fingers and toes)?

YES NO

If YES, defer immunization and consult with your doctor. Flu vaccine may slightly increase your risk for recurrence.

5. Does the person to be vaccinated have a serious allergy to eggs?

YES NO

If YES, please clarify with the recipient that the allergy is "serious". In general, persons who can eat eggs or egg product without reaction can be vaccinated. A history of anaphylactic or anaphylactic-like allergy to eggs or egg product is a contraindication to flu vaccination.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student ID #

\_\_\_\_\_  
Student Date of Birth

\_\_\_\_\_  
Printed Parent Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

Please indicate if you will be present when your child receives their vaccination. YES NO

(A schedule is attached)