Screening Checklist for Live Attenuated Intranasal Influenza Vaccine

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FluMist) today. **If you answer "yes" to any question, please see the nurse for consult immediately**. This form is to be completed by a parent/guardian for yourself and any children.

		Yes	No	Don't Know
1.	Is the person to be vaccinated sick today?	.....	.....	.....
2.	Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	.....	.....	.....
3.	Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	.....	.....	.....
4.	Is the person to be vaccinated younger than age 2 years or older than age 49 years?	.....	.....	.....
5.	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic disease, liver disease, disease (e.g. diabetes), or anemia or another blood disorder?	.....	.....	.....
6.	If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	.....	.....	.....
7.	Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as prednisone, other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or anticancer drugs; or have they had radiation treatments?	.....	.....	.....
8.	Is the person to be vaccinated receiving antiviral medications?	.....	.....	.....
9.	Is the child or teen (2-17 years) to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	.....	.....	.....
10.	Is the person to be vaccinated pregnant or could she become pregnant within the next month?	.....	.....	.....
11.	Has the person to be vaccinated ever had Guillain-Barré syndrome?	.....	.....	.....
12.	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 protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	.....	.....	.....
13.	Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	.....	.....	.....

Legal First and Last Name:	**Date of Birth:**	**Gender**	**Mother's First Name:**	**CAIR #**	**2nd Dose**
1.		☐ **M** ☐ **F**			
2.		☐ **M** ☐ **F**			
3.		☐ **M** ☐ **F**			
4.		☐ **M** ☐ **F**			

Mailing Address:	What health coverage do the persons listed have? **Check one box below:**
City:	Medi-Cal /CHDP
Zip Code:	**NO** insurance
Phone Number:	American Indian /Alaskan Native?
	Private Insurance

Parent/Guardian Signature: _____Today's Date: _____

Administered by: _____ Date: _____

Revised 9/10/15