

CASCADE FAMILY PRACTICE

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination and Consent for Injection

Patient Name _____ Date of Birth _____

Address: _____ Phone: _____

Primary Insurance: _____ Policy Number/SSN: _____

Secondary Insurance: _____ Policy Number/SSN: _____

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you inactivated injectable influenza vaccination to day. 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.

- 1) Is the person to be vaccinated sick today? Yes _____ No _____
- 2) Does the person to be vaccinated have an allergy to a component of the vaccine? Yes _____ No _____
- 3) Has the person to be vaccinated ever had a serious reaction to influenza vaccines in the past? Yes _____ No _____
- 4) Has the person to be vaccinated ever had Guillian-Barre` Syndrome? Yes _____ No _____
- 5) Is the person to be vaccinated over the age of 65 or immunocompromised? Yes _____ No _____

By signing below, acknowledging that I have completed this form, I give consent to Cascade Medical Center to administer to me or my child listed above as the patient, an inactivated injectable Influenza vaccination. Additionally, I agree to allow Cascade Medical Center to bill my insurance on my behalf and accept payment for these services, or if I have no insurance, to bill me directly for these services which I agree to pay for at the rate of \$25.00.

Patient/Parent Signature _____ Date _____

Reviewed and Administered by _____ Route/Site _____

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