Screening Questionnaire Injectable **2020-2021 Fluarix Quadrivalent Influenza Vaccine**

The following questions will help us determine if there may be reason you should not receive the injectable Influenza Vaccine today. If you answer "yes" to any questions, it does not mean you should not be vaccinated. You will be asked additional questions by the RN. Please ask the RN any further questions you may have after reading the **VIS** information flier given to you.

	Yes	**No**
1. Are you sick today?	( )	( )
2. Are you allergic to LATEX?	( )	( )
3. Do you have any allergies to eggs or egg products?	( )	( )
4. Are you allergic to Fluarix Quadrivalent Components? (Octoxynol – 10, (alpha) – Tocopheryl Hydrogen Succinate, Polysorbate 80, Hydrocortisone, Gentamicin Sulfate, Formaldehyde, Sodium Deoxycholate, Ovalbunim from the manufacturing process)	( )	( )
5.* Have you ever had any serious reaction(s) to any influenza vaccines in the past?	( )	( )
6. Have you ever had Guillain-Barre syndrome?	( )	( )
7. Do you have any bleeding disorders like hemophilia or are you on any anticoagulant therapy?	( )	( )
8. Are you pregnant / nursing a child?	( )	( )
9. Are you a household contact/caregiver of a child less than 5 years of age, of a person age 65 years or older, or to a person with chronic medical condition?	( )	( )

RN comment(s), initials, & signature: _____

2020-2021 INFLUENZA VACCINATION CONSENT FORM

I have read the Vaccine Information Statement **(VIS)** dated 08/15/2019 about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza Vaccine and request that it be given to me today. I release Santa Monica College Health Services of any liability associated with the administration of this Flu Vaccine, which is thimerosal free.

If under the age of 50, do you have any chronic condition(s)? [ ]Yes [ ]No

Explain:_____

PLEASE PRINT

_____ _____/_____/_____ _____

Last name First name Middle Birth date Age

_____

Address City Zip Phone

_____ Date: _____/_____/_____

Signature

Race / Ethnicity (optional for statistical use)

[ ] White [ ] African American
[ ] Asian [ ] Pacific Islander
[ ] Hispanic [ ] Native American
[ ] Other please designate: _____ [ ] Two or more races_____

Clinic Use Only Santa Monica College Health Services

Vaccine	Date Given	Manufacturer & Lot	Inj. Site
FLUARIX Quadrivalent	____ /____ / ____	**GlaxoSmithKline Z7275 Exp: 6/30/21**	_____

Adm. by:_____RN