PSC | Federal Occupational Health

U.S. Department of Health and Human Services

Client Screening Questionnaire and Acknowledgement Form for Inactivated Injectable Influenza Vaccination

Client's Name: _____ **Date of Birth:** _____

Screening Questionnaire for Inactivated Injectable Influenza Vaccination

Adults wanting to be vaccinated: The following questions will help determine if there is any reason you should not receive injectable influenza vaccine today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It means additional questions must be asked by the attending clinician to verify medical appropriateness for you to receive the vaccine. If a question is not clear, please ask the attending clinician for clarification.

		YES	NO	DON'T KNOW
1.	Are you sick today?			
2.	Do you have an allergy to eggs or to any component of the vaccine?			
3.	Have you ever had a serious reaction to influenza vaccine in the past?			
4.	Have you ever had Guillain-Barre Syndrome?			

Client's Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____

CLIENT ACKNOWLEDGEMENT FORM FOR 2017-18 INFLUENZA VACCINATION

The CDC recommends annual flu vaccination as the first and most important step in protecting against influenza virus. By getting vaccinated, you are not only protecting yourself, you are protecting your family, friends and co-workers. This season the influenza vaccine will protect against H1N1 virus strain. Since seasonal influenza activity usually lasts from October to May, immunization may continue from August to April. The information you provide to complete this form indicates you understand the benefits and the risks of receiving the influenza vaccine, as indicated in the CDC's Vaccine Information Statement (VIS) and are requesting to be vaccinated.

NOTE: *There is no recommendation for pregnant women or people with pre-existing medical conditions to seek special permission or secure written consent from their doctor for influenza vaccination if they are vaccinated at a worksite clinic, pharmacy, or other location outside of their physician's office. For more information, visit:* ***http://www.cdc.gov/flu/about/qa/misconceptions.htm***

Part 1: EMPLOYEE INFORMATION (Completed by client)

NAME: **Last** _____ **First** _____ **MI** _____

Last 4 digits of Social Security # XXX-XX- _____ Date of Birth (MM/DD/YYYY): _____

Worksite Address

Street _____

City _____ State _____ Zip _____

Agency _____ Work Phone # _____

Work email _____

Allergies (drug/food): _____

Medications I am currently taking: _____

Employee Signature: _____

PRIVACY ACT NOTICE

The information obtained in completing this form is used to assist Federal Occupational Health in managing its responsibilities under one or more interagency agreements with your employing agency. Collection and use of this information is consistent with provisions of 5 USC 552a, 5 USC 7901, and Public Law 103-356.

This information will become part of your official Employee Medical File (if you have one), and will be used only for official purposes as published annually in the Federal Register under OPM/GOVT-10 (the OPM system of records). Participation in the FOH Influenza vaccination campaign is **voluntary**.

PART 2: SEASONAL INFLUENZA VACCINE RECORD (Completed by clinician)

FOH Occupational Health Center:			**QUADRIVALENT INFLUENZA VIRUS VACCINE:**		
NASA Goddard Space Flight Center (H12) Bldg #97 Occupational Health Center Code 250.9 Greenbelt, MD 20771			A/Singapore/GP190B (H1N1) (an A/Michigan/45/2015 -like virus) A/Singapore/GP2050/2015 (H3N2) (an A/Hong Kong/4801/2014-like virus) B/Utah/9/2014 (a B/Phuket/3073/2013-like virus) B/Hong Kong/259/2010 (a B/Brisbane/60/08-like virus)		
Clinician's Name:	Audra Thornton / Sandra Carr / Adrian Crowe		Manufacturer:	Seqirus	
Clinician's Title:	Registered Nurse / Nurse Practitioner		Expiration Date:	4/2018	
Clinician's Signature:			Vaccine Lot #:	195128	Dose: 0.5 ml
Date:			CDC VIS Date:	August 7, 2015	
IM Injection site (check one):		Left Deltoid	Date VIS Given:		
		Right Deltoid			
If vaccine not given, provide reason why:		Contraindications			
		Client Refusal			
		Other (specify)			