**PLEASE FILL OUT ALL SECTIONS OF THIS FORM**

## SCREENING QUESTIONNAIRE FOR INACTIVATED INJECTABLE INFLUENZA AND COVID-19 VACCINATION

**For adult patients as well as parents of children to be vaccinated:** The following will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination and the Covid-19 vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please contact your healthcare provider to explain it.

| | 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 vaccine? | ▢ | ▢ | ▢ |
| 3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine and COVID-19 in the past? | ▢ | ▢ | ▢ |
| 4. Has the person to be vaccinated ever had Guillain-Barré syndrome? | ▢ | ▢ | ▢ |
| 5. Have you tested positive or been vaccinated for COVID-19 within the last 3 months? | ▢ | ▢ | ▢ |

Which vaccine will you be receiving today? Please choose 1: Flu Only ▢ Covid Only ▢ Both ▢

**Print Name:** _____ **Date of Birth:** _____

**Insurance Provider:** _____ **Member ID:** _____

***** PLEASE ALSO PROVIDE A COPY OF YOUR INSURANCE CARD *****

***By signing, I hereby consent to receive the FLU (INFLUENZA) and COVID-19 VACCINE. I understand that my insurance may not cover the vaccine, in which case, I will be responsible for the cost.***

**Signature:** _____ **Date:** _____