

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 ☐
Please check off which conditions puts you at risk for COVID:			
☐ Chronic kidney disease ☐ Obesity (BMI>30 or >95th percentile in children) ☐ Chronic lung diseases ☐ Overweight (BMI>25 kg/m2 but <30kg/m2) ☐ Chronic liver disease ☐ Sedentary Lifestyle ☐ Cystic Fibrosis ☐ Pregnancy ☐ DM 1&2 ☐ Primary immuno deficiencies ☐ Epilepsy ☐ Sickle cell disease ☐ Heart conditions ☐ Smoking, current and former ☐ HIV ☐ Substance use disorders ☐ Tuberculosis ☐ Solid-organ or blood stem-cell transplantation ☐ Use of immunosuppressive medications ☐ Mental health conditions limited to the following: ☐ Use of corticosteroids ☐ Mood disorders, including depression ☐ Schizophrenia spectrum disorders ☐ Use of immunosuppressive medications ☐ Living in the same household as immunocompromised individuals			

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:** _____