

# INFLUENZA IMMUNIZATION SCREENING AND CONSENT FORM (SF600)

Please fill in the blanks below and answer questions 1-15. Then, read and sign Patient/Guardian signature section.

**TODAY'S DATE:** \_\_\_\_\_ **SPONSOR'S BRANCH OF SERVICE** \_\_\_\_\_

**PATIENT'S NAME (Last, First, MI)** \_\_\_\_\_

**PATIENT'S DATE OF BIRTH** \_\_\_\_\_ **FULL SOCIAL SECURITY #** \_\_\_\_\_

**PATIENT IS (Circle):**

Active Duty   National Guard   Reservist   Retired   Family Member   Civilian   Contractor   DOD

**PATIENT'S UNIT:** \_\_\_\_\_ **UNIT LOCATION:** \_\_\_\_\_

- |   |            |                      |
|---|------------|----------------------|
| <b>1.</b> Are you 50 years or older?  | <b>YES</b> | <b>NO</b>            |
| <b>2.</b> Do you currently feel sick with a fever or respiratory illness?   | <b>YES</b> | <b>NO</b>            |
| <b>3.</b> Do you have an allergy to any of the following: (Circle) Eggs, Chicken or Egg Protein, Gentamicin, Gelatin, Arginine, Neomycin, Polymyxin, Thimerosal, Formaldehyde, or other Vaccine components? | <b>YES</b> | <b>NO</b>            |
| <b>4.</b> Have you ever had a serious reaction to a vaccine in the past?  | <b>YES</b> | <b>NO</b>            |
| <b>5.</b> HAVE YOU EVER HAD: Guillian-Barre syndrome, seizures, or active neurological disease?   | <b>YES</b> | <b>NO</b>            |
| <b>6.</b> Are you taking or have taken in the past 48 hours any prescription medications to prevent or treat Influenza (e.g. Tamiflu© or Relenza©)?   | <b>YES</b> | <b>NO</b>            |
| <b>7.</b> Within the last 30 days have you received a live vaccine such as: MMR, Varicella (chickenpox), Yellow Fever, Smallpox, Shingles, or Typhoid pills?  | <b>YES</b> | <b>NO</b>            |
| <b>8.</b> Do you have long-term health problems such as heart disease, kidney disease, lung disease or asthma? Any metabolic disease such as diabetes? Any blood disorder such as anemia?                   | <b>YES</b> | <b>NO</b>            |
| <b>10.</b> Do you have a weakened immune system or disorder such as: AIDS, HIV, Cancer, or received bone marrow or organ transplant?  | <b>YES</b> | <b>NO</b>            |
| <b>11.</b> Are you taking medications that weaken your immune system such as: prednisone, cortisone, other steroids, cancer drugs or radiation therapy?   | <b>YES</b> | <b>NO</b>            |
| <b>12.</b> Are you currently receiving aspirin therapy or aspirin-containing therapy of 81mg or greater?  | <b>YES</b> | <b>NO</b>            |
| <b>13.</b> Do you have close contact with anyone with a severely weakened immune system?  | <b>YES</b> | <b>NO</b>            |
| <b>14. FEMALES:</b> Are you pregnant, think you might be pregnant?  | <b>YES</b> | <b>NO</b> <b>N/A</b> |
| <b>15. CHILDREN:</b> If your child is receiving the vaccine today, how old is your child? _____ years _____ months  |            |                      |

I have read the above information and have truthfully answered all the questions on this form. I have received or have had explained to me the information in the appropriate Vaccine Information Sheet(s) (VIS). I have had the chance to ask questions, fully understanding the benefits and risk, and give consent to authorized staff to administer the influenza and/or pneumococcal vaccine to me or my child. This document contains information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. The document is to be maintained in a safe, secure, and confidential manner. Further disclosure without additional patient/ customer consent or as permitted by law is prohibited. Unauthorized additional disclosure or failure to maintain confidentiality can result in application of appropriate sanction.

**Patient or Parent/Guardian Signature:** \_\_\_\_\_

## MEDICAL STAFF USE ONLY

**ALPHA ENCOUNTER AND IMMS MODULE**

INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_

**IMMUNIZATIONS TRACKING SYSTEM**

INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_

**FLU MIST 0.2ml**                      **AFLURIA 0.25ml**  
**FLUZONE 0.5ml**                    **FLUZONE 0.25ml**  
**AFLURIA 0.5ml**

LOT # \_\_\_\_\_  
MFR: \_\_\_\_\_  
SITE: (CIRCLE) LEFT    RIGHT    NASAL

NAME OF  
SCREENER: \_\_\_\_\_  
NAME OF  
VACCINATOR: \_\_\_\_\_