NORTH COUNTRY PHARMACY

190 Munsonhurst Rd. Franklin, NJ 07416
Tel 973-827-7340 Fax 973-827-7833
info@northcountrypharmacy.com

Patient Name:_____ Date of Birth: ____/____/____
(mm) (dd) (yr)

## Screening Questionnaire for Inactivated Injectable Influenza Vaccination

For adult patients to be vaccinated:

The following questions will help us determine if there is any reason we should not give you inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necesarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare proivder to explain it.

1. Is the person to be vaccinated sick today? ☐ YES ☐ NO
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? ☐ YES ☐ NO
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ YES ☐ NO
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? ☐ YES ☐ NO

Patient Signature : _____ Date: _____

## To be completed by Pharmacist

### Influenza Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm

Dosage ☐ 0.5ml ☐ 2.5ml ☐ LAIV

Manufacturer & Lot Number _____

VIS Date _____

Pharmacist's Signature: _____ Date: _____