



## PLATTE COUNTY HEALTH DEPARTMENT

212 Marshall Road  
Platte City, MO 64079  
(816) 858-2412

1201 East Street  
Parkville, MO 64152  
(816) 587-5998

### 2011 INFLUENZA SCREENING QUESTIONNAIRE

Patient Name:	Date of Birth:		
<b>Please answer the following questions carefully.</b>	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person to be vaccinated younger than 2 years or older than age 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the person to be vaccinated receiving antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form Completed By:	Date:		
Form Reviewed By:	Date:		

**Please complete the reverse side of this form**

**Platte County Health Department Yearly Influenza Record (2011-2012)**

I have read or have had explained to me the information on the Vaccine Information Statement and the seasonal influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

**PLEASE CHECK THE BOX APPLICABLE TO YOUR INSURANCE STATUS**

- Medicare HMO     Medicare     Medicaid     Private Insurance  
 Medicare Part B     Supplemental Plan     Uninsured     Advantage Part C

<b>Full Name (Last, First, Middle Initial):</b>		<b>Date of Birth:</b>
<b>Address:</b>	<b>Age:</b>	<b>Sex:</b>
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Phone:</b>	<b>County of Residence:</b>	
<b>Medicaid/Medicare Number (If Applicable):</b>	<b>Social Security Number:</b>	
<b>Signature of person to receive this vaccine or authorized to make this request:</b>		<b>Date:</b>

**PAYMENT AGREEMENT**

I, \_\_\_\_\_, understand that if my insurance plan will not cover the flu and/or pneumonia vaccination that I am receiving today from the Platte County Health Department, that I will be receiving a bill requiring payment for received services.

<b>Signature:</b>	<b>Date:</b>
<b>Printed Name:</b>	

**FOR CLINIC USE ONLY**

<b>Manufacturer:</b>	
<b>Site:</b> <input type="checkbox"/> R Delt <input type="checkbox"/> L Delt <input type="checkbox"/> Intranasal	
<b>Type:</b> <input type="checkbox"/> VFC Flumist <input type="checkbox"/> VFC Peds <input type="checkbox"/> VFC 3+ Years <input type="checkbox"/> PCHD Peds <input type="checkbox"/> PCHD Adults	
<b>Signature:</b>	<b>Date:</b>