

Flu/Covid-19 Vaccination Screening Form

Section 1. Personal Information

First Name:	Last Name:	Age:
Patient Phone Number:		
Name of Emergency Contact:		
Emergency Contact's Phone Number:		

Section 2. Vaccine Screening Questionnaire

1. Are you currently sick today? (fever > 39.5 C, breathing problems, or active infection)	☐ Yes ☐ No
2. Do you/your child have any allergies to chemicals, medications, food, vaccine components, or latex? • <i>If yes, please specify:</i>	☐ Yes ☐ No
3. Have you/your child ever had a severe, life threatening reaction to a vaccine, or have you/your child experienced wheezing, chest tightness, or difficulty breathing within 24 hours of having a vaccine?	☐ Yes ☐ No
4. Have you/your child ever had a reaction to eggs or egg products but can still eat small amounts of egg? (e.g. stomach ache, skin reaction)	☐ Yes ☐ No
5. Have you/your child ever experienced adverse events (ie. fainting, nausea, vomiting) following a vaccine?	☐ Yes ☐ No
6. Have you/your child ever had a seizure or a brain/nervous system problem ?	☐ Yes ☐ No
7. Have you/your child ever had a history of Guillain-Barre syndrome ?	☐ Yes ☐ No
8. Do you/your child have a bleeding problem or use blood thinners ?	☐ Yes ☐ No
9. Have you /your child received any other vaccines in the past 4 weeks ? • <i>If yes, please specify:</i>	☐ Yes ☐ No