Cass County Health Department
Influenza Screening Form

Please Print

Name_____Date of Birth_____Age_____ Date_____

Full Address:_____

	Circle One	
1. Are you sick today?.....	yes	no
2. Are you pregnant?.....	yes	no
3. Do you have a severe allergy to eggs?…….....	yes	no
4. Were you ever paralyzed by Guillain-Barre Syndrome?…….	yes	no
5. Have you ever had any problems after getting the influenza vaccine?……	yes	no never had one

If yes:_____

MUST BE SIGNED BY VACCINE RECIPIENT ≥ 18 YEARS OF AGE, PARENT OR LEGAL GUARDIAN!
" I have read or have had explained to me the information on this form about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request."

Signature: _____ TIV VIS date 07/24/08

For Administrative Use Only

_____	_____		IM Delt
Date Vaccinated	Manufacture and Lot Number	Signature of Administrator	Injection Site