DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Immunization Program

Influenza and Pneumococcal Vaccine Administration Record

Today's Date (MM/DD/YYYY) __/__/20__ **Phone** ___-___-____

Last Name _____ **First Name** _____ **MI** _____

Street _____ **Zip Code** _____ **Date of Birth (MM/DD/YYYY)** __/__/____

Race
O White O Black O Asian O Native Hawaiian/Pacific Islander O American Indian/Alaskan Native O Other

Ethnicity Hispanic O Yes O No **Gender** O Male O Female **Insurance Type** O Medicare O Medicaid O None O Other

In order to receive the FluMist® nasal spray please complete the front and back of this form.

History:

	Clinician Notes
Is the person to be vaccinated pregnant?	O No O Yes_____
Is the person to be vaccinated sick today?	O No O Yes_____
Has the person to be vaccinated ever had a serious reaction to a previous dose of influenza or pneumococcal vaccine?	O No O Yes_____
Has the person to be vaccinated ever had a serious allergic reaction to any foods (especially eggs or egg products), medicines, vaccines or other substances?	O No O Yes_____
Has the person to be vaccinated ever had Guillain-Barré syndrome?	O No O Yes_____

Signature:

A signature and check mark next to the vaccine type means that I have been provided a copy of the appropriate Vaccine Information Statement and have read, or have had explained to me, information about the disease(s) and the vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits as set forth in the statement received; and I ask that the vaccine(s) as checked be given.

Check vaccine(s) requested: ☐ Influenza ☐ Pneumococcal

Signature _____ Signer Name:_____
(Please circle one) **Patient, Parent, Guardian`** **Please Print Clearly**

(For Clinician Use Only)

☐ NHS ☐ SHS Clinic Location:_____

Presentation	Dose	Site	VIS Date
O TIV O LAIV	O 0.25ml O 0.5ml O Nasal	O RA O LA O RT O LT	__/__/20__

Vaccine Date (MM/DD/YYY) __/__/20__ Lot Number _____

Presentation	Dose	Site	VIS Date
O Pneumo	O 0.5ml	O RA O LA O RT O LT	__/__/20__

Vaccine Date (MM/DD/YYY) __/__/20__ Lot Number _____

Nurse Signature: _____

Patient name: _____ Date of birth: ____/ ____/ ____
(mo.) (day) (yr.)

Screening Questionnaire for Intranasal (FluMist®) Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child intranasal influenza vaccine (FluMist®) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past?			
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?			
5. Does the person to be vaccinated have long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?			
6. 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?			
7. 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 steroids, or cancer treatment with x-rays or drugs?			
8. Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?			
9. Is the person to be vaccinated pregnant or could she become pregnant within next month?			
10. Has the person to be vaccinated ever had Guillain-Barré syndrome?			
11. 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 a protective environment (such as in a hospital room with reverse air flow)?			
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?			

Form completed by:_____ Date:_____
Form reviewed by:_____
Date:_____