BCHHC Immunization Clinic Vaccine Screening / Permission Form

The information collected on this form will be used to make sure we have permission to give vaccine. The vaccination will be recorded on Nebraska's state immunization site.

Name: _____ Date of Birth: _____ Sex: Male Female

Address: _____ City/State/Zip: _____ Phone: _____

☐ Insurance **(COPY ATTACHED)** ☐ Medicaid **(COPIES ATTACHED)** ☐ No insurance

School/Organization: _____ Doctor: _____

SCREENING QUESTIONS – ***Parent/Guardian: Please answer all the questions below with either YES or NO***

Vaccine will not be given if this form is not completed, signed and returned to school/organization 2 weeks before Flu Vaccine Day

1, Is the person getting flu vaccine sick today?	YES / NO
2. Is this person allergic to eggs, gelatin, latex, thimerosal or gentamicin?	YES / NO
3. Has this person had flu vaccine in the past?	YES / NO
4. If yes, has he/she ever had a severe allergic reaction flu vaccine?	YES / NO
5. Has this person had a seizure or a neurological problem?	YES / NO
6. Does this person have cancer, leukemia, AIDS, or any other immune system problem?	YES / NO
7. Does this person take cortisone, prednisone, other steroids, anticancer drugs, or X-Ray treatments?	YES / NO
8. Has this person received a transfusion of blood, plasma, or immune globulin in the past 6 months?	YES / NO
9. Has this person ever had Guillain-Barre syndrome?	YES / NO
10. Is this person pregnant?	YES / NO

Definitions: *Severe allergic reaction –* (anaphylaxis) – a quickly developing, exaggerated response by the body to any substance. Symptoms are reddening of skin, itching, hives, runny or stuffy nose, swelling of the lips, tongue, and/or throat, trouble swallowing, trouble breathing, anxiety, fast irregular heartbeat, and cramping in the abdomen.

Thimerosal – a preservative found in some vaccines.

Gentamicin – An antibiotic medicine.

Guillain-Barre Syndrome – A disease of the nerves. Symptoms are muscle weakness and decreased feeling beginning in the legs and moving upward, sometimes causing a person to be paralyzed or have trouble breathing.

Permission: I have been given a copy of the Influenza Vaccine Information Statement, and I have read and/or have had explained to me the information on influenza (flu) disease and influenza (flu) vaccine. I've had the opportunity to ask questions and have those questions answered to my satisfaction. I understand the risks and benefits of vaccination against influenza (flu), and I request that the influenza (flu) vaccine be given to me or the person named above for whom I am authorized to make this request. I understand and agree that Public Health Solutions and my child's school are not responsible for any adverse reactions that may occur and that it is my responsibility to seek medical attention for my child or myself should an adverse reaction occur.

Patient/Parent/Legal Guardian Signature: _____ Date: _____

Patient/Parent/Legal Guardian Printed Name: _____ Date of Birth: _____

Relationship to Patient: _____