MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
NAVHLTHCLINICPAXRIVINST 6230.3S	20 MAR 2018
LOCAL FORM TITLE *(Optional)*	
INFLUENZA SCREENING AND IMMUNIZATION	

Please Check One: ☐ **ACTIVE DUTY** ☐ **DEPENDENT** ☐ **RETIREE** ☐ **BENEFICIARY**

If you answer "yes" to any question, it does not necessarily mean you 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.

	Check the Yes or No Box to answer questions 1-12:	***Yes***	***No***
1	Have you ever had a serious reaction to a previous FLU vaccine?	☐	☐
2	Do you currently feel sick, have a fever or have a respiratory illness?	☐	☐
3	Do you have a long-term health problem with asthma, heart disease, lung disease, liver disease, kidney disease, metabolic disease (e.g. diabetes), anemia, HIV, or other blood disorder?	☐	☐
4	Have you had any food or medication reactions?	☐	☐
5	Are you allergic to eggs, egg protein, or chicken protein?	☐	☐
6	Do you have an allergy to neomycin, polymyxin, gentamicin, gelatin, or arginine?	☐	☐
7	Have you ever developed Guillain-Barre Syndrome (muscle paralysis) within 6 weeks of receiving the influenza vaccine?	☐	☐
8	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks?	☐	☐
9	Are you taking any prescription medicines to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	☐	☐
10	Females ONLY: Are you pregnant or planning to become pregnant in the next month?	☐	☐
11	Pediatric Patient ONLY: Is your child currently taking aspirin?	☐	☐
12	If your child is between 6 months and 8 years of age, has your child received at least 2 doses of flu vaccine before 1July2018?	☐	☐

I have read or have had explained to me the information in the Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and the risks of the Influenza vaccine.

☐ Contraindicated, Not Given ☐ Declined

☐ 5 yrs and older, 0.5 mL, IM Deltoid

☐ 6 months and older, 0.5 mL, IM Deltoid Lot #

☐ 6-35 months, 0.5 mL, IM Dose 1 Dose 2

Site of Administration: RIGHT DELTOID / LEFT DELTOID RIGHT THIGH / LEFT THIGH
(Please Circle)

PATIENT'S NAME	PATIENT'S SIGNATURE	DATE
PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	