Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. 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.

	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 a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?	☐	☐	☐

Your provider has recommended a vaccine for you today. While we do our best to provide general information regarding the likelihood of your insurance covering this vaccine, there are countless individual insurance plans. Ultimately it is the responsibility of each individual patient to know what their specific insurance plan will cover. We encourage you to call the number listed on your insurance card if you have any questions about the specific coverage benefits of you particular plan.

Once Creekside Medical has drawn the agreed upon vaccine; I agree to be personally and fully responsible for payment, even if I change my mind and no longer want them administered.

If my insurance carrier denies full or partial payment, I agree to be personally and fully responsible for payment.

Patient Signature: _____ Date: _____

FORM COMPLETED BY _____

FORM REVIEWED BY _____ DATE _____