Screening Checklist for Contraindications to Injectable Influenza Vaccination for Adults

Patient Name _____

Date of Birth _____/_____/_____

For Adults to be vaccinated: The following questions will help us determine if there is any reason we should not give you your inactivated injectable influenza vaccination 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 an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

form completed by_____date_____

form reviewed by_____date _____

Insurance Info
Rx Bin:
Rx PCN:
Rx Group:
Rx ID:
Card Holder Name:

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number/Expiration	Name and Title of Vaccine Administrator
Influenza (Afluria)	IM Deltoid □ L / □ R	10/14/2026	Seqirus	□ 418649/ 06-11-2027 (Single-dose)	□ Joseph Romph Pharmacist □ Andy Mai Pharmacist □ Chris Birman Pharmacist