MERCER COUNTY
CELINA CITY
Health Department
PREVENT • PROMOTE • PROTECT

PLEASE ANSWER THE TOP QUESTIONS FOR ALL FLU VACCINES

	YES	NO
1. Is the person to be vaccinated sick today?	○	○
2. Does the person to be vaccinated have an allergy to eggs, latex or component of the vaccine? .	○	○
3. Has the person to be vaccinated ever had a serious reaction to any influenza vaccine in the past?	○	○
4. Has the person to be vaccinated ever had Guillain-Barre syndrome?	○	○

****PLEASE ANSWER FOR PATIENTS RECEIVING THE FLUMIST (NASAL) VACCINATION ONLY****

	YES	NO
5. Is the person to be vaccinated younger than age 2 or older than age 49 years?	○	○
6. Does the person to be vaccinated have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), anemia or another blood disorder?	○	○
7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS or another immune system problem; or, in the past 3 months have they taken medications that weaken the immune system such as cortisone, prednisone, anticancer drugs or cancer treatment with radiation?	○	○
8. Is the person to be vaccinated receiving antiviral medications?	○	○
9. Is the person to be vaccinated (2 years through 17 years) receiving aspirin therapy or aspirin-containing therapy?	○	○
10. Is the person to be vaccinated pregnant, or planning to become pregnant in the next month?	○	○
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 protective isolation (e.g. an isolation room of a bone marrow transplant unit)?	○	○
12. Has the person to be vaccinated received any other vaccinations in the past four weeks?	○	○
13. If the child to be vaccinated is between 2 and 4 years old, has a health-care provider stated the child had wheezing or asthma in the past 12 months?	○	○

I grant permission to the Mercer County-Celina City Health Department to give the requested vaccination to myself or the person named above for whom I am authorized to make this request (as Parent or Guardian). I have read or had explained to me the information from the Vaccine Information Statement and understand the risks and benefits of this vaccine. I have received or been offered the HIPAA Privacy Notice and the Vaccine Information Statement 8-7-2015.

Patient/Parent or Guardian::

PRINTED NAME_____

SIGNATURE_____ **DATE**_____

FOR HEALTH DEPARTMENT USE ONLY

FORM REVIEWED AND VACCINE ADMINISTERED BY _____ DATE: _____ Time_____

Lot#_____ Site_____