Community Care Physicians 2024-2025 Flu Season Questionaire

COVID Screening Questionnaire

Have you tested positive for COVID-19 in the past 10 days? (Y/N)

Have you had contact with anyone who has had a positive COVID-19 test in the past 10 days? (Y/N)

***Please note, you answered YES to <u>any</u> of the above questions, you may not be able to receive your influenza vaccine until you are fever/symptom free for 72 hours and at least 10 days past exposure.**

If you answered NO to all of the above questions, please complete the remainder of the form.

Influenza Vaccine Screening Form **Date___/___/____**

Patient's Name _____ DOB: __/__/_____ MRN: _____

Are you allergic to eggs? □ **Yes** □ **No**

Have you ever had a reaction to the flu shot? □ **Yes** □ **No**

Have you ever had Guillain-Barré Syndrome? □ **Yes** □ **No**
(Tingling or weakness in the legs and feet that can progress to full-body weakness and paralysis)

Are you feeling sick today, with or without fever? □ **Yes** □ **No**

WOMEN ONLY, PLEASE: Are you pregnant? □ **Yes** □ **No**

Signature of patient/parent/legal representative _____

Relationship (if other than the patient) _____

<u>Office USE Only:</u>

In the absence of an affirmative ("yes") response to the questions below, please administer influenza vaccine, using an age-appropriate dose and product, to the patient.

Ordering practitioner onsite _____

Updated 8/22/24