

Print Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ MUID: \_\_\_\_\_

## Marquette University Medical Clinic

### Screening Questionnaire for Adult Immunization

The following questions will help us determine if the seasonal Influenza vaccine may be given to you. Please answer the questions below by checking the boxes. If the question is unclear to you, please ask your health care provider to explain it to you.

	YES	NO	Don't Know
Are you feeling ill today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies to any component of the vaccine. For example: eggs or thimerosal. If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with Guillain-Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**I have been provided a copy of the Influenza Vaccine Information Sheet and have read it or have had it explained to me. I have had a chance to ask questions that were to my satisfaction. I believe that I understand the benefits and risks of the Influenza vaccine and request that it be given to me.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Manufacturer: Seqirus Afluria (Quadrivalent)**

**Lot #AS3616B**

**IM \_\_\_\_\_ Deltoid**

**Expiration Date: 06/30/2023**

**Provider's Signature: \_\_\_\_\_**

**Date / Time: \_\_\_\_\_**