MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **2016 - 2017**	**Seasonal Influenza Vaccination Program Screening & Immunizations** The proponent agency for this form is MCHF-PMS.	OTSG APPROVED *(Date)* *(YYYYMMDD)*

The following questions will help us determine if we should give you the intranasal or the injectable influenza vaccination today. If you answer "Yes" to any question, we will ask additional questions to determine which vaccine, if *any you will receive. Please speak to your health care provider, if you have any questions.* Please complete all the blanks in the patient information section.

Check appropriate box when answering questions 1 - 5.

1.	Do you currently have a respiratory illness or a fever?	☐ Yes ☐ No
2.	Have you ever had a serious or life threatening reaction to the flu vaccine?	☐ Yes ☐ No
3.	Do you have a history of Guillain-Barre' Syndrome (GBS)?	☐ Yes ☐ No
4.	Do you have an allergy to: EGGS, LATEX, or other vaccines?	☐ Yes ☐ No
5.	Answer **ONLY** if your child is 6 months to 8 years of age; has your child received at least 2 doses of flu vaccine before 01 July 2016?	☐ Yes ☐ No ☐ N/A

"I have read or have had explained to me the Influenza Vaccine Information (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risk of the influenza vaccine."

Patient's Signature and Date: _____ _____

THIS BOX IS FOR ADMINISTRATIVE USE ONLY

☐ Give injectable flu vaccine today
☐ Do not administer flu vaccine today
☐ Vaccine Information Statement provided
☐ **Inactivated Influenza Vaccine (IIV4)**
☐ **Inactivated Influenza Vaccine (IIV3)**

Interviewer's Signature _____ Date_____

Inactivated Influenza Manufacturer: ☐ **Seqirus (Afluria)** ☐ **GlaxoSmithKline (Fluarix)** ☐ **Sanofi Pasteur (Fluzone)**

Vaccine Lot Number: _____

Vaccine Expiration Date: _____

Site of Administration:

☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh

☐ Dose 0.5 ml IM ☐ Dose 0.25 ml IM

PREPARED BY *(Signature & Title)* VACCINE ADMINISTERED BY Print Name & Title: _____ Signature: _____	DEPARTMENT/SERVICE/CLINIC _____ Dwight D. Eisenhower Army Medical Center	*DATE (YYYYMMDD)* *(Continue on reverse)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

Name (Last, First, MI): _____

Rank: _____ DOB (MM/DD/YYYY): _____

Patient Prefix (20,30, 01): ____ Full SSN (mandatory): _____

Unit: _____ (Required for MEDPROS/MRRS/ASIMS input)

Check appropriate boxes that pertain to patient:

☐ Army ☐ Marines ☐ DoD ☐ Foreign National ☐ Navy ☐ Air Force

☐ Coast Guard ☐ Contractor ☐ Active Duty ☐ Reserve ☐ Beneficiary/Retiree

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

_____