Keep in a safe place

RECORD OF INFLUENZA (FLU) AND PNEUMOCOCCAL IMMUNIZATION(S)

white copy → immunizer; yellow copy → client

Date	Name: Last, First	Carecard #	Birthdate (dd/mm/yyyy)	Gender

SCREENING QUESTIONS BEFORE RECEIVING THE INFLUENZA VACCINE
(Please check off either yes or no for each question below)

1. Have you had any problems with previous flu vaccines?
   Yes ☐ No ☐
2. Do you have any severe life-threatening allergies to the following? *a previous dose of vaccine or a component of the vaccine?*
   Yes ☐ No ☐
3. Do you have a disease/treatment which lowers your immunity?
   Yes ☐ No ☐

ADDITIONAL SCREENING FOR **FLUMIST ONLY**

4. Are you currently receiving aspirin therapy or aspirin-containing therapy?
   Yes ☐ No ☐
5. Are you currently on treatment for asthma?
   Yes ☐ No ☐
6. Are you pregnant or think you may be pregnant?
   Yes ☐ No ☐

Address	Phone #	PARIS ID

Trade name	Dose #	Lot #	Site	Immunizer Signature
Influenza (Flu) Afluria ☐ Fluzone **Quad** ☐ FluLaval ☐ Fluzone **HD** ☐ Flumist ☐ *Other:* ____________			Deltoid L ☐ R ☐ Intranasal ☐	
Pneumococcal			L ☐ R ☐	

☐ **Informed consent authorized by:**
Minor children and adults unable to self-consent
Print name and relationship to client

Children who are 8 years and younger and receiving a flu shot for the first time require a second flu shot in 4 weeks.

☐ **Flu shot #2 due in 4 weeks. Date** ____________

Need more information? Call 811 or visit www.healthlinkbc.ca

Vancouver CoastalHealth

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