

Gasconade-Osage County Health Department

H1N1 Vaccination Screening

Name: _____

Age: _____

	YES	NO	Does not apply
Do you have a severe allergy to eggs?			
Do you have any other severe allergies? Please list: _____			
Are you ill today?			
Are you pregnant or is there a chance that you could be pregnant?			
Do you have close contact with a severely weakened immune system?			
Do you have a weak immune system? (Such as HIV, cancer, medications such as steroids or those used to treat cancer)			
Do you have a long term medical condition: such as asthma, lung problems, heart disease, kidney disease, diabetes, or blood disorders?			
Have you ever had Guillain-Barre Syndrome (temporary muscle weakness) after receiving flu vaccine?			
If a child, on long term aspirin therapy?			
Have you ever had a serious reaction to a previous dose of influenza vaccine?			
Have you been on an antiviral medication within the last 48 hours?			
Have you received any other vaccine, (not just flu) within the last 30 days? Please list: _____			

If yes to any of the above please describe: _____

Signature: _____

Date: _____