Adult Vaccine Screening Checklist- FLU/COVID

Please check (✓) the vaccine(s) you plan to receive today: Influenza □ COVID-19 □

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to

Patient Label
Name:_____
DOB:_____
PCP:_____

Answer YES or NO to each question below by circling "Yes" or "No".

1	Are you sick today?	YES	NO
2	Do you have allergies to medications, food, a vaccine component, or latex?	YES	NO
3	Have you ever had a serious reaction after receiving a vaccine?	YES	NO
4	Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	YES	NO
5	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO
6	Do you have a parent, brother, or sister with an immune system problem?	YES	NO
7	In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	YES	NO
8	Have you had a seizure or a brain or other nervous system problem?	YES	NO
9	Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	YES	NO
10	In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	YES	NO
11	Are you pregnant?	YES	NO
12	Have you received any vaccinations in the past 4 weeks?	YES	NO
13	Have you ever felt dizzy or faint before, during, or after a shot?	YES	NO
14	Are you anxious about getting a a shot today?	YES	NO

Please scan QDR code(s) for Vaccine Information Statement
Paper copies are available upon request

COVID-19 Vaccine [mRNA]

Influenza (Flu) Vaccine (Inactivated or Recombinant)

By signing below, you give consent to be vaccinated by The Corvallis Clinic staff and acknowledge that you have read the vaccine information statement (VIS) for any applicable vaccines and understand the risks and benefits.

_____ / _____ / _____

Completed by: Print Name & Relationship Signature **(patient or legal guardian)** Today's Date

The Corvallis Clinic

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If any "yes" answers, form was review by:
Clinician Name:

_____

☐ Verbal order to proceed with administration(s) ☐ Verbal order given to reschedule vaccine(s) ☐ Verbal order not give Vaccine(s)

CLINIC USE ONLY

Mfr.	Vaccine	Dose	Site	Location	VIS Date	Lot # / Exp. Date
Private Vaccines						
Seqirus	FLUCELVAX Influenza Vaccine (≥6m)	0.5 mL	Deltoid | Vastus Lateralis	R | L	01/31/2025	Lot # _____ Exp. Date _____
Seqirus	FLUAD influenza vaccine, adjuvanted (≥65yr)	0.5 mL	Deltoid | Vastus Lateralis	R | L	01/31/2025	Lot # _____ Exp. Date _____
moderna	spikevax COVID-19 Vaccine, mR (≥12yr)	0.5 mL (50 mcg)	Deltoid | Vastus Lateralis	R | L	1/31/2025	Lot # _____ Exp. Date _____

Administered by _____ / _____ / _____

Name (print) *Signature* *Today's **Date** & **Time***