Fluzone High Dose 65+

Community Care Physicians 2022/2023 Flu Season Questionnaire

COVID Screening Questionnaire

Are you currently experiencing any of the following symptoms? (Y / N) *TEMP*_____

- Fever or chills
- Shortness of breath or difficulty breathing
- Muscle or body aches
- New loss of taste or smell
- Congestion or runny nose
- Diarrhea
- Cough
- Fatigue
- Headache
- Sore throat
- Nausea or vomiting

Have you tested positive for COVID-19 in the past 14 days? (Y / N)

Have you had contact with anyone who has had a positive COVID-19 test in the past 10 days? (Y / N)

***Please note, if you answered YES to <u>any</u> of the above questions, you will not be able to receive your influenza vaccine until you are fever/symptom free for 72 hours and at least 10 days past exposure.**

If you answered **NO to all** of the above questions, please complete the remainder of the form.

Influenza Vaccine Screening Form **Date___/___/_____**

Patient's Name _____ DOB: ___/____/_____

Are you allergic to eggs? □ **Yes** □ **No**

Have you ever had a reaction to the flu shot? □ **Yes** □ **No**

Have you ever had Guillain-Barré Syndrome? □ **Yes** □ **No**
(Tingling or weakness in the legs and feet that can progress to full-body weakness and paralysis)

Are you feeling sick today, with or without fever? □ **Yes** □ **No**

WOMEN ONLY, PLEASE: Are you pregnant? □ **Yes** □ **No**

Signature of patient/parent/legal representative _____

***<u>Office USE Only</u>*:**

In the absence of an affirmative ("yes") response to the questions above, please administer influenza vaccine, using an age-appropriate dose and product, to above named patient.

Influenza Vaccine given per standing order. Practitioner onsite _____

Sticker: MAN: SANOFI PASTEUR NDC#: #: 49281-0122-65

Dose 0.7 ml IM Deltoid: L R Lateral Thigh: L R

Nurse's signature_____ Date:_____