COMMUNITY CARE PHYSICIANS

**Community Care Physicians 2025-2026 Flu Season Questionnaire**

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

Patient's Name _____ DOB: __/__/_____ MRN: _____

**Have you had a history of a severe allergic reaction (e.g. anaphylaxis) to any previous dose of influenza vaccine?** □ **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 _____

Relationship (if other than the patient) _____

*Office USE Only:*

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

**Ordering practitioner onsite _____**

Updated 8/19/2025