

Walton County Health Department H1N1 Vaccination Campaign Screening Tool

Name: _____ Date of Birth: _____ Age: _____
(Please Print)

Are you allergic to Eggs? NO YES*

Are you allergic to any other medications? NO YES (If YES, please list) _____

Are you on any antiviral medication? NO YES* (If YES, when was the last dose?) _____

Are you pregnant? NO YES*

Are you a child under the age of 5 with recurrent wheezing? NO YES*

Do you have a weakened immune system? NO YES* (If YES, please describe)

Have you ever had a severe reaction to a flu vaccination? NO YES* (If YES, please describe)

Do you any of the following medical conditions? (If YES, please circle)

CANCER	CHRONIC LUNG DISEASE (Asthma, COPD)	DIABETES
HEART DISEASE	BLOOD DISORDER	LIVER DISORDER
NEUROLOGICAL DISORDER	NEUROMUSCULAR DISORDER	OTHER

For Office Use Only

Priority Target Groups (Check correct box)

Pregnant	Age 6 months to 24 years	Caregiver of children < 6 months	Healthcare Worker	High Risk Condition	None

_____ Do not vaccinate, due to _____

Explanation

Signature

Date

_____ Vaccinate as noted below _____

Signature

Date

Vaccine Selection Guide

	<i>1st choice</i>	<i>2nd choice</i>	<i>3^d choice</i>
LAIV (nasal spray)			
Multi dose injectable .5ml			
Multi dose injectable .25ml			
Unit dose preservative free 15 mg (.5ml)			
Unit dose Preservative Free 7.5 mg (.25ml)			

Comments
