Osage County Health Department
205 E. Main Street, Linn, MO 65051
573-897-3103

Name of school or clinic site: _____

circle one please: Flu shot/ Flumist

I/My child has ☐ Private Insurance [please provide copy of card(s)]

☐ Medicaid/No Insurance/Insurance that doesn't cover shots (Please consider a $20 donation to cover costs of supplies) No one will be turned away for inability to pay.

If your child is 8 years old or younger, have they received the flu vaccine before? ☐ Yes ☐ No ☐ N/A

Screening Questionnaire for Flu Immunization (Please fill out COMPLETELY and print CLEARLY)

Patient Name: _____ __ Date of Birth:_____ Age:_____

Phone Number: _____ Sex: Male / Female

Address: _____ Mailing Address: _____

_____ _____

Fax to Physician: Y / N Physician:_____

For your information: If you answer "yes" to any question, it does not necessarily mean you/your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it. Please call the health department with any questions ahead of time.

1. Are you/your child sick today?	Yes	No	Don't know
2. Are there allergies to medications, food, a vaccine component, or latex?	Yes	No	Don't Know
3. Has there a serious reaction to a vaccine in the past?	Yes	No	Don't Know
4. Is there a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is she/he on long-term aspirin therapy?	Yes	No	Don't Know
5. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	Yes	No	Don't know
6. Do you or the child have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No	Don't Know
7. In the past 3 months, have you or the child taken cortisone, prednisone, or other steroids, or anticancer drugs, or had radiation treatment?	Yes	No	Don't Know

CONTINUED ON BACKSIDE

8. In the past year, have you or the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Yes No Don't Know

It is important to have a personal record of YOUR/your child's vaccinations. If you don't have a personal record, ask the healthcare provider to give you one with all the vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care. This important document may be needed for the rest of his/her life to enter day care or school, for employment, or for international travel. **Please provide a copy of any updates to the school or doctors office if applicable, or bring a copy to the Osage County Health Department for permanent recording.**

VISs will be given to those school children receiving the shot on the day of the vaccination. I have had a chance to ask questions and had them answered to my satisfaction before my child received the flu vaccine. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or the person named above for whom I am authorized pursuant to Section 431.058 RMSo to make this request.

Signature: _____(Circle: Self/Parent/Guardian/Designee) **Date:** _____

Section 4: Vaccination Record - FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dosage	VIS Given	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Private	/ /	IM R L	0.5 cc	08/15/2019	6mo + GSK	55R79 Exp 06/30/2020	
		IM R L□	0.5 cc	08/15/2019			
		IM R L	0.25 cc	08/15/2019			
		IM R L	0.5 cc	08/15/2019			
VFC/317 (circle one)	/ /	IM R L	0.5 cc	08/15/2019			
		□IM R L	0.5 cc□	08/15/2019			

Child needs second dose in 1 month? Y/N

Manufacturer _____ Lot # _____
Expiration Date _____ VIS Date_____
Site: RA LA RT LT Dose
_____Signature of Administrator

Manufacturer _____ Lot # _____
Expiration Date _____ VIS Date_____
Site: RA LA RT LT Dose
_____Signature of Administrator