PATIENT NAME: _____

DATE OF BIRTH: _____

COVID Screening Questions

Check Yes or No

Y ☐ N ☐ Have you, your child or any of your close contacts travelled outside the city or state in the last 30 days?

Y ☐ N ☐ Have you had any visitors at your house that have travelled outside the city or state in the last 30 days?

Y ☐ N ☐ Have you, your child or any of your close contacts been exposed to someone with a positive COVID test?

Y ☐ N ☐ Are you, your child, or any of your or your child's close contacts currently waiting for COVID test results?

Y ☐ N ☐ Have you, your child or any of your close contacts been in gatherings of 10 or more people?

Y ☐ N ☐ Are there any positive cases of COVID at the employer for this child's parents or legal guardians?

Y ☐ N ☐ If your child is old enough to work, are there any positive cases of COVID at your child's employer?

Y ☐ N ☐ Are you, anyone in your child's home or your close contacts currently experiencing any COVID symptoms such as runny nose, cough, congestion, fever, shortness of breath, loss of sense of taste or smell?

Y ☐ N ☐ Are you, anyone in your child's home or your close contacts currently experiencing any other type of symptoms or illness?

Y ☐ N ☐ Is your child involved in sports or other activities? Have there been any reported cases? Do they use a mask during sports/activities?

Y ☐ N ☐ Is your child in school or daycare? Have there been any reported cases? What are their school or daycare requirements for masking?

Y ☐ N ☐ Do you, your child and all of your close contacts wear masks while in public (grocery store, church, get togethers, etc)

Screening for Contraindications to Inactivated Injectable Influenza Vaccination

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your shild inactivated injectable influenza vaccination today. if you answer "yes" to any question, it does not necessarily mean you (or 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.

Check Yes, No, or Don't Know

Y ☐ N ☐ DK ☐ Is the person to be vaccinated sick today?

Y ☐ N ☐ DK ☐ Does the person to be vaccinated have an allergy to a component of the vaccine?

Y ☐ N ☐ DK ☐ Has the person to be vaccinated ever had a serious reaction to influenze vaccine in the past?

Y ☐ N ☐ DK ☐ Has the person to be vaccinated ever had Guillain-Barré syndrome?

Parent Signature: _____ Date: _____

Nurse Signature _____ Date: _____