MEDICAL SCREENING & CONSENT FORM (Rev 05/26/04)
Avian Flu Vaccination Clinic DRILL

Patient ID#: _____

Personal Information

Date: ____/____/____ **PLEASE USE A FAKE NAME**

Last Name: _____ First Name: _____MI: _____

Home Address: _____ Apt #: _____

City: _____ State: _____Zip Code: _____

Are you a Health Care Worker: □ No □ Yes

Occupation: _____Employer: _____

Work Address: _____ City: _____ State: _____

Home Phone: (___) ____-_____ Work Phone: (___) ____-_____ Cell Phone: (___) ____-_____

Email Address: _____

Age: _____ Date of Birth: _____/_____/_____ Gender (circle one): M F

Are you <u>currently</u> ill with a fever greater than 100.4 F or 38.0 C? □ No □ Yes
Last documented fever was: _____ F or C

Have you developed flu-like symptoms or cough in the past week? □ No □ Yes

Have you ever had any of the following medical conditions?
Allergic reaction to eggs □ No □ Yes
Reaction to any vaccine requiring medical care □ No □ Yes
History of Guillain-Barre Syndrome □ No □ Yes

Current Medical Status:
Pregnant or planning to become pregnant in next 4 weeks? □ No □ Yes
Are you breastfeeding? □ No □ Yes
Immunocompromised, including HIV/AIDS, chemotherapy, transplant patient, lupus, lymphoma, leukemia, platelet disorder, thrombocytopenia? □ No □ Yes
Chronic lung disease or severe breathing problems? □ No □ Yes
Severe Asthma? □ No □ Yes
Uncontrolled or fever-induced seizures, or neurological disease? □ No □ Yes
Other serious health problems or surgeries in the last six months? □ No □ Yes

Are you presently taking <u>any</u> medications, including over-the-counter medications?
□ No □ Yes If yes, please list them:

_____

_____

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Do the following apply to anyone in your household?			
Immune system problems such as HIV/AIDS, cancer, leukemia, lymphoma, organ transplant, agammaglobulinemia, low platelets	□ No	□ Yes	□ Don't know
Autoimmune problems like lupus that weaken your immune system	□ No	□ Yes	□ Don't know
Currently taking medicines like oral steroids (such as prednisone), chemotherapy, agents/radiation, or organ transplant medications	□ No	□ Yes	□ Don't know
Currently pregnant or plan to become pregnant in next 4 weeks	□ No	□ Yes	□ Don't know
Age less than 1 year old	□ No	□ Yes	□ Don't know
History of Guillain-Barre syndrome or serious reaction to a vaccine	□ No	□ Yes	□ Don't know
History of seizures or neurological disease	□ No	□ Yes	□ Don't know

Do you have any questions you would like to ask before you decide on vaccination?	□ No	□ Yes
Are you less than 18 years of age and your parent or guardian is not with you?	□ No	□ Yes
This adult is incapacitated and this screening/consent form is being completed by the parent or guardian (checked box for this question alone does not require additional screening)	□ No	□ Yes

Participant Informed Consent Signature for Vaccination:

I HAVE:

- Received, read and understand the Facts about Avian Flu and the risks and benefits of Mock Avian Flu vaccine;
- Considered my own health status as well as the health status of my household members and close physical contacts;
- Had the opportunity to discuss any medical concerns with a health care screener at the vaccination clinic; and
- Responded to all questions on this form and asked of me honestly and to the best of my ability.

I understand the decision to be vaccinated is voluntary and agree to proceed with the Mock Avian Flu vaccination.

_____ _____
Patient (or Parent/Guardian) Signature Date

_____ _____
Medical Screener Signature Date

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FOR HEALTH CARE PROVIDERS USE ONLY:

Comments/notes for clarification:

_____

_____

_____

_____

_____

Disposition:

□ **Referred for Vaccination**

□ **Deferred due to medical contraindications**

□ **Vaccination refused**

Medical Screener's Initials: _____ *Date:* _____

Vaccine Clinic Information		**Vaccine Batch Information**	
Name:	*Yolo County Health Department*	**Vaccine Type:**	*Mock Avian Flu*
Contact:	*Myrna Epstein*	**Program:**	*Yolo County Avian Flu Vaccination Drill*
Phone:	*(530) 666-8645*	**Vaccine Lot #:**	
Fax:	*(530) 666-8674*	**Vaccine Lot Manufacturer**	
Address:	*10 Cottonwood Street Woodland, CA 95695*		

Vaccine administered by: _____
(Please enter first & last name, and professional suffix (MD, RN, etc))

Arm inoculated: □ Right □ Left
Date of Vaccination: _____/_____/_____