COUNTY OF SAN LUIS OBISPO DEPARTMENT OF PUBLIC HEALTH
Suzanne Jed, MSN, RN *Director of Public Health*
Rick Rosen, MD, MPH *Interim County Health Officer*

Screening Questionnaire for Seasonal Influenza Vaccination

Last Name: _____ First Name: _____

Birthdate (mm/dd/yyyy): _____ Age: _____ If <9 yrs, has child had two flu vaccines before? Yes ❒ No ❒

Mother's First Name: _____ Gender: Male ❒ Female ❒ Decline to state ❒

Phone Number: _____

	Yes	No	I don't know
Is the person to be vaccinated sick today?	❒	❒	❒
Does the person to be vaccinated have an allergy to an ingredient of the influenza vaccine?	❒	❒	❒
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	❒	❒	❒
Has the person to be vaccinated ever had Guillain Barre' Syndrome?	❒	❒	❒
Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	❒	❒	❒
Is the person to be vaccinated anxious about getting a shot today?	❒	❒	❒

September 2026

I have read, or have had explained to me, the information contained in the Vaccine Information Sheet or the appropriate Important Information Statement(s) about the disease(s) and vaccine(s) indicated below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named below for whom I am authorized to make this request.

Authorized Signature: _____ Date: _____

Acknowledgment of Notice of Privacy Practices
I hereby acknowledge that I have been offered or have received a copy of San Luis Obispo County Health Agency's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area of each clinic, and I will be offered a copy.

Signature of Patient or Parent/Guardian: _____ Date: _____

If Parent/Guardian, State Relation to Patient:
_____

For office use only:

Vaccine Lot #: _____
Check one: MIST _____ -or- Injectable _____ Inj. Site _____
Vaccine Brand Name _____
Check one: STATE Vaccine _____ -or- Private Pay _____
Administered by: Nurse Signature _____ Date _____