Markham Family Medicine Teaching Unit
Health for All
FAMILY HEALTH TEAM

QUESTIONNAIRE FOR MOBILE INFLUENZA VACCINE CLINIC

Evaluation Questionnaire

1. Do you have a family doctor or nurse practitioner YES NO
If no, reason _____
2. When you are feeling unwell where do you go to seek medical attention? Family physician Walk in clinic ED
3. Did you get a flu shot last year? If yes, do you remember where you got it from? Comment:_____ YES NO
4. Have you fallen in the last 6 months? If Yes, reason _____ YES NO
5. Do you have LHIN services? YES NO

RISK SCREENING QUESTIONNAIRE

Have you had a previous reaction to the influenza vaccine?	YES	NO
Are you allergic to thimerosal?	YES	NO
Are you allergic to formaldehyde?	YES	NO
Do you have an allergy to arginine or gelatin?	YES	NO
Do you have an allergy to gentamicin?	YES	NO
Do you have an allergy to sodium deoxycholate?	YES	NO
Do you have an allergy to sucrose?	YES	NO
Do you have any other known allergies?	YES	NO
Have you had Oculo-Respiratory Syndrome (ORS) after influenza vaccine?Are you congested or with mild respiratory symptoms (i.e. common cold,. cough)?	YES	NO
Do you currently have a severe infection and/or fever?	YES	NO
Are you pregnant or nursing?	YES	NO
Is your immune level compromised? e.g. on chemo, steroids, HIV/AIDS	YES	NO
Do you have a history of Guillian-Barre Syndrome?	YES	NO
Do you have an evolving neurological illness?	YES	NO
Do you have a bleeding disorder or are you on blood thinners?	YES	NO
Are you taking any antiviral medication (oseltamivir , zanamivir, or peramivir)?Do you currently have severe asthma or active wheezing?	YES	NO
Are you under the age of 18 and currently taking aspirin?	YES	NO
Is the client under 9 years of age?	YES	NO
Is the client a member of a risk group**?	YES	NO
Have you read the Influenza Fact Sheet?	YES	NO
Have your questions been answered by the nurse?	YES	NO

Sex: Male Female

Age group: 19-64 65+ years

Last influenza immunization: ____/____/____
MM/DD/YYYY

**refers to people at high risk of influenza-related complication (eg. Elderly or very young and ill) and people capable of transmitting influenza to those at high risk of influenza related complications (eg. Healthcare providers)

Markham Family Medicine Teaching Unit
Health for All
FAMILY HEALTH TEAM

QUESTIONNAIRE FOR MOBILE INFLUENZA VACCINE CLINIC

Required COVID-19 Screening Questions

1. Do you have any of the following new or worsening symptoms or signs?

Symptoms should not be chronic or related to other known causes or conditions.

Fever or chills	☐ Yes	☐ No
Difficulty breathing or shortness of breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Sore throat, trouble swallowing	☐ Yes	☐ No
Runny nose/stuffy nose or nasal congestion	☐ Yes	☐ No
Decrease or loss of smell or taste	☐ Yes	☐ No
Nausea, vomiting, diarrhea, abdominal pain	☐ Yes	☐ No
Not feeling well, extreme tiredness, sore muscles	☐ Yes	☐ No
Pink eye (conjunctivitis)	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

2. If you are 70 years of age or older, are you experiencing any of the following symptoms?

Delirium	☐ Yes	☐ No
Unexplained or increased number of falls	☐ Yes	☐ No
Acute functional decline	☐ Yes	☐ No
Worsening of chronic conditions	☐ Yes	☐ No

3. Have you travelled outside of Canada in the past 14 days?

☐ Yes ☐ No

4. Have you had close contact with a confirmed or probable case of COVID-19 within the last two weeks?

☐ Yes ☐ No

Results of Screening Questions:

If you answered YES to any questions from 1 through 4, please refrain from participating in our Flu Clinic and contact your health care provider or Telehealth Ontario (1 866-797-0000) to find out if you need a COVID-19 test.

Markham Family Medicine Teaching Unit
Health for All
FAMILY HEALTH TEAM

QUESTIONNAIRE FOR MOBILE INFLUENZA VACCINE CLINIC

CONSENT FOR INFLUENZA IMMUNIZATION

I, _____ (print name) have been screened by the nurse for risk associated with influenza immunization. I have read the flu information sheet and have had all my questions answered to my satisfaction. I understand why I am receiving this immunization, the risks and possible adverse reactions associated with it. I hereby give consent to receive:

Time: _____ Expiry date: _____

Name of vaccine: _____ Route: _____

Lot number: _____ Site: _____

Dose: _____ Clinic site: _____

I also give my consent to share my flu vaccination status with Markham Stouffville Hospital in the event I am brought to the ED or admitted to the hospital and not provided with a second flu shot.

_____ _____

Date (MM/DD/YYYY) Client Signature

_____ _____

Date (MM/DD/YYYY) Nurse's Signature & Designation

Client's Tolerance of Immunization:

FOR PATIENT TO KEEP

I, (print name) have been screened by the nurse for risk associated with influenza immunization. I have read the flu information sheet and have had all my questions answered to my satisfaction. I understand why I am receiving this immunization, the risks and possible adverse reactions associated with it. I hereby give consent to receive:

Time: _____ Expiry date: _____

Name of vaccine: _____ Route: _____

Lot number: _____ Site: _____

Dose: _____ Clinic site: _____

I also give my consent to share my flu vaccination status with Markham Stouffville Hospital in the event I am brought to the ED or admitted to the hospital and not provided with a second flu shot.

_____ _____

Date (MM/DD/YYYY) Client Signature

_____ _____

Date (MM/DD/YYYY) Nurse's Signature & Designation

Client's Tolerance of Immunization: