



FLU IMMUNIZATION HIGH RISK ASSESSMENT

In an effort to vaccinate high-risk individuals, Maxim Health Systems, in accordance with the Centers for Disease Control (CDC) guidelines, have identified medical conditions and factors that place you at high risk of developing complications from the flu. You must answer yes to one or more of the following questions to receive the flu vaccine at this time. If you are not considered high-risk, you will not be vaccinated by Maxim at this time. Please check a box for each numbered question and fill out the information below.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. ARE YOU 65 YEARS OR OLDER? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. DO YOU RESIDE IN A NURSING HOME OR CHRONIC CARE FACILITY? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. DO YOU HAVE LUNG OR HEART DISEASE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. DO YOU HAVE ASTHMA? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. DO YOU HAVE A CHRONIC METABOLIC DISEASE: KIDNEY, BLOOD, OR DIABETES? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. ARE YOU IMMUNOSUPPRESSED? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. IF YOU ARE A PARENT OR LEGAL GUARDIAN, IS YOUR CHILD RECEIVING LONG TERM ASPIRIN THERAPY? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. ARE YOU PREGNANT? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. ARE YOU A HEALTHCARE WORKER DIRECTLY INVOLVED IN PATIENT CARE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. ARE YOU AN OUT OF HOME CAREGIVER OR HOUSEHOLD CONTACT FOR CHILDREN LESS THAN 6 MONTHS OF AGE? | <input type="checkbox"/> | <input type="checkbox"/> |

PRINT NAME _____

SIGNATURE: _____ DATE: _____

PHYSICIAN NAME: _____

PHYSICIAN ADDRESS _____

PHYSICIAN CITY, STATE, ZIP _____

PHYSICIAN PHONE _____