Protocol ID: _____

Study Name: _____

Site: _____

Event Name: _____

Event Date: _____

Study Subject ID:_____

Interviewer Name:_____

Interview Date:_____

BLSA Flu Vaccine - V1.0

Section Title: Eligibility

Instructions:

BLSA Flu Vaccine Eligibility

Date Completed ☐ Blank

Tester ID

Is the participant eligibility been determined as HLA-2A? ○ Yes ○ No Click to deselect entry

Is the participant able to provide consent ○ Yes ○ No Click to deselect entry

Is the participant 70-80 yrs of age? ○ Yes ○ No Click to deselect entry

Does the participant agree to the blood draws and and the follow up visits?
Days 7 and 21 ○ Yes ○ No Click to deselect entry

Does the participant report feeling well today? ○ Yes ○ No Click to deselect entry

Is the participant currently without evidence of illness, i.e. afebrile, no cough/congestion, nausea/vomiting?	○ Yes ○ No	Click to deselect entry
Is the participant without allergy to eggs? If they can eat eggs, it is ok	○ Yes ○ No	Click to deselect entry
Does the participant deny an previous serious reactions to the flu vaccine? *Serious reactions do not include fever, malaise, myalgia, and/or other mild to moderate systemic reactions or pain, redness or swelling to injection site and/or other mild to moderate local reactions.*	○ Yes ○ No	Click to deselect entry
In the past 2 years, has the participant had a reaction to the flu vaccine (see above)	○ Yes ○ No	Click to deselect entry
Has the participant been told not to have the flu vaccine?	○ Yes ○ No	Click to deselect entry
Is the participant without evidence or history of Guillain-Barre syndrome?	○ Yes ○ No	Click to deselect entry
Is the participant without MCI or Dementia diagnosis?	○ Yes ○ No	Click to deselect entry
Did the participant receive a flu vaccine more than 8 months ago?	○ Yes ○ No	Click to deselect entry
Has the participant been afebrile with no reports of upper respiratory infection in the past month?	○ Yes ○ No	Click to deselect entry

Does the participant deny using immunosuppressant medications every day? *Review current medication list*	○ Yes ○ No	Click to deselect entry
Does the participant deny using anti-inflammatory medications every day? *Review current medication list*	○ Yes ○ No	Click to deselect entry
Does the participant deny current treatment for cancer?	○ Yes ○ No	Click to deselect entry
Participant is not anemic per current visit CBC. Hemoglobin men >11.9 gm/dL Hemoglobin woman > 10.5 gm/dL	○ Yes ○ No	Click to deselect entry
Participant satisfies all eligibility criteria.	○ Yes ○ No	Click to deselect entry
Name of person completing eligibility		

Protocol ID: _____
Study Name: _____
Site: _____
Event Name: _____
Event Date: _____

Study Subject ID:_____
Interviewer Name:_____
Interview Date:_____

Section Title: Day 0

Instructions:

Day 0

Date

Eligibility criteria confirmed ○ Yes ○ No Click to deselect entry
Side effects reviewed

Vital Signs

Body Temperature (°F)

Pulse (beats/min) Respirations (breath/min)

Systolic (mmHg) Diastolic (mmHg)

Blood Draw

Fasting ○ Yes ○ No Click to deselect entry

Blood draw Done ○ Yes ○ No Click to deselect entry

Blood draw # of attempts

Location ○ Right arm ○ Left arm ○ Both Click to deselect entry

○ Anticubital ○ Upper arm ○ Lower arm ○ Hand Click to deselect entry

Time drawn: ○ Am ○ Pm Click to deselect entry

Comment

Flu Vaccine
To be completed by Pharmacist

Flu Vaccine Type

Flu Vaccine Lot#

Dispensed by

Date

Flu Vaccine Administratin

Tester ID

Injection site ○ Right arm ○ Left arm Click to deselect entry

Post flu vaccine instructions provided ○ Yes ○ No Click to deselect entry

Protocol ID: _____
Study Name: _____
Site: _____
Event Name: _____
Event Date: _____

Study Subject ID:_____
Interviewer Name:_____
Interview Date:_____

Section Title: Day 7

Instructions:

Day 7 +/- 1

Date

Vital Signs

Body Temperature	(°F)		
Pulse	(beats/min)	Respirations	(breath/min)
Systolic	(mmHg)	Diastolic	(mmHg)

Blood Draw

Fasting ○ Yes ○ No Click to deselect entry

Blood draw Done ○ Yes ○ No Click to deselect entry

Blood draw # of attempts

Location ○ Right arm ○ Left arm ○ Both Click to deselect entry

○ Anticubital ○ Upper arm ○ Lower arm ○ Hand Click to deselect entry

Time drawn: ○ Am ○ Pm Click to deselect entry

Comment

Flu Vaccine Symptom Review Questionnaire

During the past week have you had any of the following **NEW** symptoms?

Chest Pain	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Vomiting	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Severe headache	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Shortness of breath	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Fever, aches and/or chillls	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Cough	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Severe fatigue	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
In the past week, or since you last talked to staff, have you been hospitalized or had an emergency room visit?	○ Yes ○ No	Click to deselect entry			

Review vitals. Notify BLSA medical staff of ***Yes*** and ***Still Present*** responses and/or abnormal vital signs associated with symptoms.

Comment

Protocol ID: _____
Study Name: _____
Site: _____
Event Name: _____
Event Date: _____

Study Subject ID:_____
Interviewer Name:_____
Interview Date:_____

Section Title: Day 21

Instructions:

Day 21 +/- 2

Date

Vital Signs

Body Temperature	(°F)		
Pulse	(beats/min)	Respirations	(breath/min)
Systolic	(mmHg)	Diastolic	(mmHg)

Blood Draw

Fasting ○ Yes ○ No Click to deselect entry

Blood draw Done ○ Yes ○ No Click to deselect entry

Blood draw # of attempts

Location ○ Right arm ○ Left arm ○ Both Click to deselect entry

○ Anticubital ○ Upper arm ○ Lower arm ○ Hand Click to deselect entry

Time drawn: ○ Am ○ Pm Click to deselect entry

Comment

Flu Vaccine Symptom Review Questionnaire

During the past week have you had any of the following **NEW** symptoms?

Chest Pain	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Vomiting	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Severe headache	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Shortness of breath	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Fever, aches and/or chillls	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Cough	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
Severe fatigue	○ Yes ○ No	Click to deselect entry	Is this still present	○ Yes ○ No	Click to deselect entry
In the past week, or since you last talked to staff, have you been hospitalized or had an emergency room visit?	○ Yes ○ No	Click to deselect entry			

Review vitals. Notify BLSA medical staff of ***Yes*** and ***Still Present*** responses and/or abnormal vital signs associated with symptoms.

Comment