MANNINO'S
Family Practice Pharmacy

113 W Charles Street | Hammond, LA 70401

VACCINE PRESCRIPTION, PATIENT INFORMED CONSENT AND RECORD OF VACCINE ADMINISTRATION FOR **INFLUENZA** VACCINE

Date:_____

Patient: _____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____DOB: _____ Age: _____ Gender: _____

Race: _____ Mother's Maiden Name: _____

Primary Doctor: _____

I, Authorize the pharmacy staff of Mannino's Family Practice Pharmacy to administer Influenza Vaccine to myself/my child or minor of which I am guardian (as applicable).I have been provided the Vaccine Information Statement (Date: 08/15/2019) and understand the benefits and risks of receiving this vaccine. I understand the possible side effects. I have had the opportunity to ask questions of the pharmacist. I understand that notification of this vaccine administration will be sent to the primary care physician listed above and to the Louisiana Immunization Network for Kids Statewide (LINKS). I have also been given a copy of Mannino's Pharmacy HIPAA policy. I also authorize Mannino's Pharmacy to bill Medicare, Medicaid or any other applicable third party on my behalf. In addition, understand that I am responsible for any deductible or coinsurance not paid by the third party and agree to pay the unpaid amount.

_____ _____

Signature Date

Vaccine prescribed and administered: INFLUENZA

BRAND	MANUFACTURER	LOT #	EXP DATE	VACCINE GIVEN
Afluria Quadrivalent	SEQUIRIS	P100115067	06/26/2020	
Fluzone High-Dose	SANOFIPASTUER	UJ241AB	04/18/2020	

Date administered: _____ Amount administered: 0.5cc

Route: IM Site of administration: Deltoid Muscle Right [ ] Left [ ]

Prescribed and Administered by:_____

Richard Mannino, RPh [ ] Vincent Rusciano, RPh [ ]
Robert Nethery, RPh [ ] Sadie M. Bennett, PharmD [ ]

SCREENING QUESTIONNAIRE

1. **Are you sick today?**
   Yes or No
2. **Do you have allergies to medications, food, a vaccine component or latex?**
   Yes or No
   If Yes, please list: _____
3. **Have you ever had a serious reaction after receiving a vaccination?**
   Yes or No
4. **Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?**
   Yes or No
5. **Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?**
   Yes or No
6. **In the past 3 months, have you taken medication that weakens your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?**
   Yes or No
7. **Have you had a seizure a brain or other nervous system problem?**
   Yes or No
8. **During the past year have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?**
   Yes or No
9. **Are you pregnant or is there a chance you could become pregnant during the next month?**
   Yes or No
10. **Have you received any vaccinations in the past 4 weeks?**
    Yes or No

Completed by: _____ Date: _____

Reviewed by: _____ Date:_____