Screening Questionnaire for Inactivated Injectable Influenza Vaccination

Patient Name_____ Date of Birth _____/_____/_____
Male ☐ Female ☐

Address_____ Zip code_____ Phone Number_____

Physician First Name: _____ Last Name:_____
Clinic Location: _____ If you would like your physician notified, please provide fax #_____

For Patients: The following questions will help us to determine if there is any reason we should not give you an inactivated injectable influenza vaccination today. Answering yes to any of the following questions does not make you ineligible; it just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain.

	Yes	No
1. Are you **under** the age of 18?	☐	☐
2. Are you feeling sick today?	☐	☐
3. Do you have an allergy to eggs, gelatin, neomycin, medications or vaccines?	☐	☐
4. Have you ever had a serious reaction after a vaccine in the past?	☐	☐
5. Have you ever had Guillain-Barre syndrome?	☐	☐

Consent For Influenza Vaccination

I have read, or had explained to me, the vaccine information Statement for influenza vaccine. I understand the risks and benefits, and have been provided an opportunity to ask questions, and they have been answered to my satisfaction. I wish to receive the influenza vaccine and hereby authorize Sweetgrass Pharmacy to administer the vaccine, bill my insurance company for this service and communicate the administration of the vaccine to my primary care provider, who is listed above.

_____ _____ 08/15/19
Recipient's (or legal representative's) signature *Today's date* *VIS Date*

Pharmacy –Based Vaccination Record

A pharmacist administering influenza vaccine pursuant to this protocol must create a vaccination record for each vaccine, and must maintain this record for a period of at least ten (10) years. Report any and all adverse events on back.

_____ _____
Vaccine Lot *Vaccine Expiration*

L R IM ☐ High dose
Injection site

☐ Regular

_____ _____
Pharmacist/Intern License *Pharmacist/Intern Name*

Pharmacy use - Billing Information: BIN_____ PCN_____ ID_____ Rx Grp_____
Medicare Part B: Member ID _____

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