6635 Falls of Neuse Rd
Raleigh, NC 27615
Phone 919.676.6161
Text 919.646.2997
Fax 919.676.6575

Screening Questionnaire, Consent, and Physician Fax Form

Patient Information: Please complete both the front (top portion only) and back of this form.

*Patient Name_____ *Date of Birth_____ *Weight _____

*Address_____ *City_____ *State____ *Zip_____*Gender M or F

*Phone#_____ ☐ Cell ☐ Home *Email_____

☐ OUR FREE MOBILE APP OFFERS 2-WAY MESSAGING! CHECK HERE TO RECEIVE A TEXT WITH THE LINK TO DOWNLOAD IT!

*Medical Conditions_____

*Primary Insurance_____*Medicare Beneficiary ID (if applicable)_____
**Have our RxLocal Mobile App? Send us a picture of your insurance card via the app
**You may also TEXT a picture of your insurance card to 919.646.2997

*Which vaccine would you like to receive today? *Primary Doctor_____

☐ Flu Vaccine (quadrivalent)
☐ High Dose Flu Vaccine (for age ≥65)

_____**Stop here and continue on to the BACK of this form →**

Pharmacy Use Only/Physician Notification: Dr. Fax#_____

Dear Doctor: Today the above patient was vaccinated at our store. Please retain for your records.

Name of Vaccine Administered	VIS Date	Lot/Expiration
☐ IIV4 Fluzone Quadrivalent PF	8/15/2019	(see sticker above)
☐ IIV4 Fluzone High Dose (65+) Quadrivalent PF	8/15/2019	

Vaccine Administrator Name & Title _____, Pharmacist

Signature _____

If Applicable, Intern Name_____

Date VIS given to patient_____ Date Administered_____

Injection Site LA or RA (Circle one)

☐ Medicare Part B Member ID # _____
☐ Other _____

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Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For patients: The following questions will help us determine if there is any reason we should not give you the 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 Pharmacist to explain it.

	Yes	No	Don't Know
*1. Are you feeling sick today?	☐	☐	☐
*2. Do you have allergies to eggs, latex, or to a vaccine component?	☐	☐	☐
*3. Have you ever had a serious reaction to the influenza vaccine in the past?	☐	☐	☐
*4. Have you ever had Guillain-Barré syndrome?	☐	☐	☐

Consent for Influenza Vaccination

- I acknowledge that the Pharmacist recommends that vaccinated patients should remain in the waiting area, after the administration of the vaccine, for 20 minutes.

- I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Medicap. I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.

- **Consent:** I have read, or have had read to me the Vaccine Information Sheet (VIS) regarding the influenza vaccine. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine. I fully release and discharge Medicap Pharmacy, its affiliates, their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

***Patient Signature** _____ ***Date**_____
(OR parent/guardian signature if under 18)

Form reviewed by: _____, Pharmacist