Patient Influenza Administration

Name: _____ **Sex:** □ Male □ Female **DOB:** _____
Last, First M.I. MM/DD/YYYY

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #_____ **Email:** _____

Patient's SSN : _____-_____-_____ **Mother's Maiden Name**: _____

Race: □ White □ Black □ Other: _____ **Ethnicity**: □ Hispanic □ non-Hispanic

Primary Physician: _____ **Allergies:** □ **None** □ **Other:** _____

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

	Yes	No	Don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain Barré Syndrome?	☐	☐	☐

I hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically relates facility, pharmacy, insurance company or government agency to disclose or furnish to Teche Drugs, Inc., or his representatives, any and all information with respect to any illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatments, or benefits and copies of all applicable records that may be requested. A photo static copy of this authorization is to be considered as valid as the original.

Form Completed By: _____ **Relationship:** _____

Patient (or caregiver) Signature: _____ **Date:** _____

For Office Use Only		INJECTION(S)	INJ. SITE	LOT	EXPIRATION DATE
		Influenza: QIV 0.5ML	IM L / R: DELT. / THIGH / HIP		
		Influenza: HD (65+) TIV 0.5ML	IM L / R: DELT. / THIGH / HIP		
		OTHER:	IM L / R: DELT. / THIGH / HIP		

Vaccine Administrator:_____ Date: _____

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