



## Patient Influenza Administration

<b>Name:</b> _____			<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>DOB:</b> _____	
Last,	First	M.I.			MM/DD/YYYY	
<b>Address:</b> _____		<b>City:</b> _____		<b>State:</b> _____		<b>Zip:</b> _____
<b>Phone #</b> _____			<b>Email:</b> _____			
<b>Patient's SSN :</b> _____ - _____ - _____			<b>Mother's Maiden Name:</b> _____			
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other: _____				<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> 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.

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

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:** \_\_\_\_\_

	INJECTION(S)	INJ. SITE	LOT	EXPIRATION DATE
For Office Use Only	Influenza: IIV3 0.5ML	IM L / R: DELT. / THIGH / HIP		
	Fluzone HD-IIV3 0.5ML (65+)	IM L / R: DELT. / THIGH / HIP		
	OTHER:	IM L / R: DELT. / THIGH / HIP		

**Vaccine Administrator:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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