Patient Influenza Administration

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

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

Home Phone #: _____ **Cell Phone #**_____ **Email:** _____

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

Race: □Hispanic/ Latino □Black/ African American □White □Other: _____

Primary Physician: _____

Drug Allergies: None Aspirin Amoxil Penicillin Sulfa Codeine Iodine **Other:** _____

Medical Conditions: Angina Asthma Diabetes Glaucoma Heart Disease High Blood Pressure

Other: _____

How did you hear about us? □ Physician □ Family □ Friend □ Internet □ Phone Book □ Other_____

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.

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

509 JEFFERSON STREET LAFAYETTE, LA 70501
TEL: (337) 235-4578 FAX: (337) 235-4570
EMAIL: techedrugs@cox.net **WEBSITE:** www.techedrugs.com

REVISION DATE: 9/15/2021

Screening Checklist for Contraindications to Influenza Vaccination

Patient's name _____

Date of birth : _____

Please answer all questions below.		YES	NO	DON'T KNOW
For Flu Shot: Complete 1-3	**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 influenza vaccine?	☐	☐	☐
	3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
For Flu Mist: Complete 1 - 13	**4.** Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
	5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, disease (e.g,diabetes), or anemia or another blood disorder?	☐	☐	☐
	6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a health care provider told you the child had wheezing or asthma?	☐	☐	☐
	7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that affect the immune system, such as prednisone, other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anticancer drugs; or have they had radiation treatments?	☐	☐	☐
	8. Is the person to be vaccinated receiving influenza antiviral medications?	☐	☐	☐
	9. Is the person to be vaccinated a child or teen age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
	10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
	11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
	12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
	13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

I have read or have had explained to me written information about the vaccine(s) being received today. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me or to the person named below for whom I am authorized to make this decision.

Form completed by: _____ **Relationship**: _____

Patient or Caregiver Signature: _____ **Date**: _____

For Office Use Only:

Vaccine	Injection Site:	Lot#	Expiration
	IM / SQ: L/R: DELT. / THIGH / HIP/ INTRANASAL		

Medication Administrator: _____	Date: _____

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