Screening Questionnaire for Inactivated Injectable Influenza Vaccine (Afluria Quad) 20-21 Season

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☐ MIIC

Patient Name ______________________ Date of Birth ______________
Address ______________________ Phone Number ______________
Primary Care Provider's Name ______________ Clinic Name/Location ______________

The following questions will help us determine if there is any reason we should not give you an inactivated influenza vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated, it just means additional questions must be asked. If a question is not clear, please ask your healthcare 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 any food, medication or vaccine component?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barre' syndrome?	☐	☐	☐
5. Has the person to be vaccinated ever had a seizure?	☐	☐	☐
6. Does the person to be vaccinated weigh less than 130 pounds (60 kg)?	☐	☐	☐
7. Does the person to be vaccinated weigh more than 200 pounds (90kg) for women or 260 pounds (118 kg) for men?	☐	☐	☐

Form completed by (if other than patient): ______________________

I authorize Kemper Drug to administer the vaccine and to bill my insurance company for this service. I understand that if I have a copay, or the vaccine or it's administration fee is not covered under my insurance policy, that I will be responsible for the copayment or cost for this service.
I agree that I will not hold Kemper Drug and/or its agents responsible for any liability, loss, charge, damage or expense caused or incurred by me as a result of my receiving or failure to receive any vaccination.

Signature: ______________________ Date: ______________

Afluria Quad Vaccine, Sequirus
33332-0420-10 0.5ml
Exp 6/22/2021 Lot: ☐P100250838
☐P100244637
Deltoid L _______ R _______
Date _________ Initials __________

☐ Given VIS for Influenza Vaccine (8/15/2019)

Form reviewed by: ______________________ RPh PharmD Date ______________

Kemper Drug, 323 Jackson Ave NW, Elk River, MN 55330