

Screening Form: Inactivated Influenza Vaccine

Date: _____

Name: _____ DOB: _____ Male Female
Last First MI

Address: _____
Street City State Zip

Phone: () _____ Doctor's Name & Clinic: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS **BEFORE** RECEIVING YOUR VACCINE:

- | | Yes | No | Unsure |
|---|--------------------------|--------------------------|--------------------------|
| 1. Are you 65 years old or older ?
If yes , please provide your Medicare Part B card and ID: _____
<i>*** If yes, RPh may recommend HIGH-DOSE vaccine ***</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you sick today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have allergies to eggs and/or latex?
If yes , do <u>not</u> administer vaccine today. Instead refer patient to primary care provider. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a serious reaction after receiving a flu shot or other vaccination? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been paralyzed by Guillain-Barre Syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you 6 to 8 years old ?
If yes , RPh must refer to algorithm (on back of this form)
Based on algorithm, patient should receive:
<input type="checkbox"/> 2 doses of influenza vaccine this season, separated by at least 4 weeks
<input type="checkbox"/> 1 dose of influenza vaccine this season | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

My signature below indicates that I have read and understand all the information provided to me about the vaccine and that I have answered the above questions truthfully.

*Note – **Cash** Paying Patients: My signature below verifies that to the best of my knowledge, the vaccine I am receiving today could **NOT** be paid by any other source such as employer sponsored health plan, federal grant or black lung program or I have chosen to pay cash even if the vaccine is covered by my private medical insurance.*

Patient / Guardian Signature _____ Date: _____

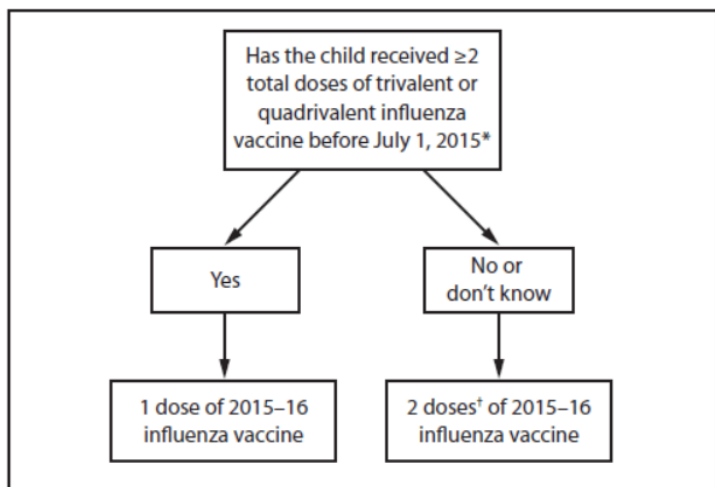
PHARMACY USE ONLY

Inactivated Influenza Vaccine (0.5ml) given IM	Arm: <input type="checkbox"/> Left <input type="checkbox"/> Right	VIS provided? <input type="checkbox"/> Yes <input type="checkbox"/> No (Publication Date: 8/7/15)
Formulation: <input type="checkbox"/> QUADRIVALENT <input type="checkbox"/> HIGH-DOSE	Mfr: Sanofi	Lot and Expiration Date <i>**Place Sticker in Box**</i> <div style="border: 1px dashed black; padding: 5px; text-align: center; margin: 5px 0;"> ** PLACE MANUFACTURER STICKER HERE ** </div>

Given by: _____ RPh / Student (Patient ≥ 18 yrs? Yes No)
 Supervising RPh: _____

- Part B? Billed thru HL
 Faxed to Central Ops (203-4900)
 Record documented in HL

FIGURE 1. Influenza vaccine dosing algorithm for children aged 6 months through 8 years – Advisory Committee on Immunization Practices, United States, 2015–16 influenza season



* The two doses need not have been received during the same season or consecutive seasons.

† Doses should be administered ≥4 weeks apart.