Screening Form: Inactivated Influenza Vaccine

Date: _____

Name: _____ Birthdate: _____ 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: _____			
**** If **yes**, RPh may recommend **HIGH-DOSE** vaccine ****			
2. Are you **sick** today?	☐	☐	☐
3. Do you have **allergies** to eggs, latex or a component of the vaccine?	☐	☐	☐
If **yes**, do not administer vaccine today. Instead refer patient to primary care provider.			
4. Have you ever had a serious **reaction** after receiving a flu shot or other vaccination?	☐	☐	☐
If **yes**, do not administer vaccine today. Instead refer patient to primary care provider.			
5. Have you ever been paralyzed by **Guillain-Barre** Syndrome?	☐	☐	☐
If **yes**, do not administer vaccine today. Instead refer patient to primary care provider.			
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:
- ❑ 2 doses of influenza vaccine this season, separated by at least 4 weeks
- ❑ 1 dose of influenza vaccine this season

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**: ☐Left ☐Right	**VIS** provided? ☐Yes ☐No (Publication Date: 8/7/15)
Formulation: ☐QUADRIVALENT ☐HIGH-DOSE	**Mfr** ☐GSK ☐Sanofi	Lot and Expiration Date **(Place sticker or record)**

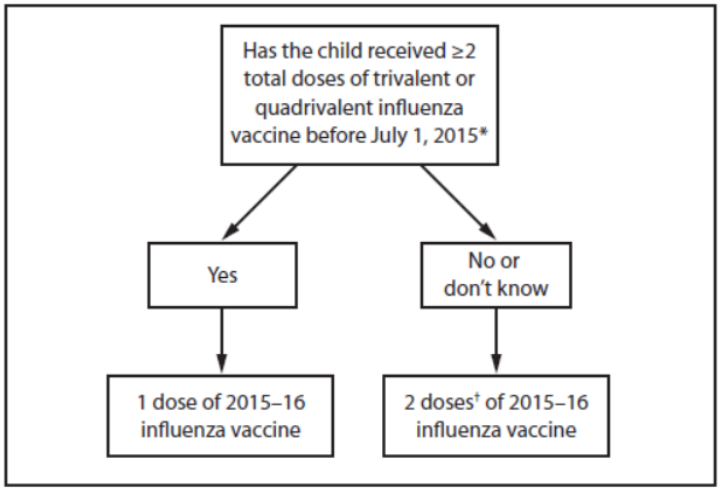
Given by: _____ RPh / Student (Patient ≥ 18 yrs? ☐ Yes ☐ No) Time: _____

Insurance/Payment: ☐ **Medicare Part B** ☐ **Insurance (i.e. Unity) / Cash** Supervising RPh: _____

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

Updated (7/18)

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.