VALLEY PHARMACY

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Patient Name:_____ Date of Birth: ___/___/____
(mm) (dd) (yr)

Phone Number:_____

Address: _____ City, State, Zip _____

Patient Social Security Number or Medicare Number : _____

Insurance_____RX Bin#_____RX PCN# _____RX GROUP#_____ID#_____

Screening Questionnaire for Inactivated Injectable Influenza Vaccination

For adult patients to be vaccinated:

The following questions will help us determine if there is any reason we should not give you inactivated injectable influenza vaccination 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.

1. Is the person to be vaccinated sick today? ☐ YES ☐ NO
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? ☐ YES ☐ NO
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ YES ☐ NO
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? ☐ YES ☐ NO

Patient Signature : _____ Date: _____
(Parent Signature and Consent if patient is under 18 years of age)

To be completed by Pharmacist

Influenza Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm

Dosage ☐ 0.5ml ☐ 2.5ml ☐ LAIV

Manufacturer & Lot Number _____

VIS Date _____

Pharmacist's Signature: _____ Date: _____