2020-21 Influenza Immunization Consent Form

and Screening Questionnaire

- **Personal Information**

Patient Name: _____ **Date of Birth**: ____/_____/_____

Gender: Male or Female **Address**: _____

Primary Phone #: Cell or Home (_____)-_____-_____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone #: Cell or Home (_____)-_____-_____

Primary Care Physician: _____

Primary Care Physician Phone #: (_____)-_____-_____

- **Screening Questions (Please answer with yes, no, or not applicable)**

1. If you are over the age of 50, have you ever had the shingles vaccine? _____
2. If you are over the age of 65, have you ever had a pneumococcal vaccine? _____
3. Are you pregnant or planning on becoming pregnant? _____

- **COVID-19 Questionnaire**

1. Do you have any new signs or symptoms of a respiratory infection, sore throat, cough, shortness of breath, malaise, diarrhea, dizziness, loss of taste/ smell, rash? _____
2. In the last 14 days, have you had contact with anyone confirmed or probable positive case of COVID, respiratory infection, or anyone that has traveled recently? _____
3. Do you reside or work in a community where the spread of COVID is occurring? (Ex. household, apartment building, nursing home, etc.) _____
4. Have you traveled out-of-state recently? _____
   If yes, specify the state and dates: _____
5. Have you been exposed to someone with COVID-19 recently? _____

- **Influenza Information**

Inactivated Influenza Vaccine - Administered via injection - available for those 6 months old +

Created from a dead virus, the flu vaccine will not give you the flu. It is injected into the muscle. Some vaccines contain a preservative called thimerosal, and thimerosal-free vaccines are available upon request. Side effects include soreness, redness, or swelling at the injection site. Fever, hoarseness, red/itchy eyes, fatigue, and muscle aches are also possible. These symptoms may begin after the injection and can last for one to two days. High-dose inactivated influenza vaccine is also available for those 65 years +.

Live Attenuated Influenza Vaccine - Administered via nasal spray - available for those 2 years old - 49 years old

Live but attenuated, meaning weakened virus, that is sprayed into the nostrils. Side effects in children aged 2 years old to 17 years old include runny nose, nasal congestion, cough, fever, wheezing, headache, muscle ache, and abdominal pain with or without occasional vomiting and diarrhea. Side effects are more mild in adults and occur less frequently. Side effects in adults aged 18 years old to 49 years old include runny nose, nasal congestion, cough, chills, tiredness, weakness, sore throat, and headache. These symptoms may last a few days after the administration.

❖ **Signatures**

I understand the benefits and risks involved with the vaccines described in the Vaccine Information Statement (VIS), which has been provided to me with this consent and release form. I request the administration of the vaccination to be given to me or the person named above, a minor for whom I represent and have the authority to sign this consent and release form in the name of.

Signature of Person Receiving Vaccine (or Guardian if recipient is a minor):_____

Print of Guardian Name and Number (if recipient is a minor): _____

I have received a copy of the notice of Privacy Practices and appropriate VIS form courtesy of the CDC. I understand the notice of Privacy Practices and the ways in which my health information may be used or disclosed within the pharmacy and my rights associated with it. I understand the pharmacy complies with the HIPAA law and have been provided an opportunity to discuss concerns in regards to the privacy of my health information.

Signature of Acknowledgement of Privacy Practices, VIS, and HIPAA: _____

I consent to the pharmacy taking my temperature via a non-contact infrared thermometer and recording it on this form. I also agree to wear a mask and follow current CDC recommendations for the safety of pharmacy staff and myself during the vaccine administration.

Signature of Acknowledgement of COVID-19 precautions: _____

Patient Temperature: _____℉

Pharmacy Use Only

Vaccine	Date of Administration	Lot #	Exp. Date	MFR	Dosage	Inj. Site	VIS Date
Afluria (6mo. +)		P10024 0256	05/27/2021	Seqirus	0.25ML 0.5ML	LD RD	08/15/2019
Afluria (3yrs. +, Preservative Free)		P10022 9509	05/26/2021	Seqirus	0.25ML 0.5ML	LD RD	08/15/2019
Fluad Quad		279781	05/12/2021	Seqirus	0.5ML	LD RD	08/15/2019

Signature of Administering Pharmacist: _____