Patient Name:____

Today's Date:____________________________ Date of Birth:____________________________

Screening Questionnaire for Adult Influenza Immunizations

This form helps us to decide which vaccines should be given in the pharmacy today. Please answer the following questions. Please see the pharmacist when completed.

1. Did you have a flu vaccine last year? Yes or No

2. Are you sick today? Yes or No
   (If you are currently sick enough to go to the doctor or emergency room, you should postpone receiving a flu vaccine.)

3. Do you have allergies to medications? Yes or No

4. Do you have allergies to eggs, any vaccine component? Yes or No

5. Have you ever had a serious reaction after receiving a vaccine? Yes or No

6. Do you, any person who lives with you, or any person you take care of, have cancer, leukemia, AIDS, or any other immune system problem? Yes or No
   (Answering "Yes" is an extra reason to receive a flu vaccine.)

7. Do you, any person who lives with you or any person you take care of, take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments? Yes or No
   (Answering "Yes" is an extra reason to receive a flu vaccine.)

8. During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin? Yes or No

9. For women: Is it possible that you are pregnant or may become pregnant in the next three months? Yes or No
   (Note: Influenza vaccines are recommended in pregnancy)

If you don't have an immunization record card with you, let the pharmacist know. Bring this card with you to your clinic and immunization visits. Make sure your vaccinations are recorded on it.

Updated 6.30.04

2011 INFLUENZA VACCINE
ADMINISTRATION RECORD

METHOD OF PAYMENT:

[ ] CASH [ ] INSURANCE [ ] MEDICARE(E-RX) MEDICARE #: ______________________________

**** Have Medicare card available for confirmation. ****

For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart.

DO YOU HAVE : MEDICARE COMPLETE; HOMETOWN;
PRIMETIME; KAISER PERMANENTE; SUMMA CARE; UNITED HEALTHCARE?

******IF YES, WE CANNOT BILL. PAYMENT METHOD IS CASH ONLY******

PATIENT INFORMATION: *(Permanent home information)*****

NAME: LAST: ________________________ FIRST: ____________________ M.I. ______

ADDRESS: __________________________ CITY: _____________________ STATE: ________

ZIP: ____________ COUNTY: _________________ PHONE #: ___________________

SEX: M _______ F_______ DATE OF BIRTH: ____________________ WT: ______

CHRONIC ILLNESS? YES _______ NO _______

FAMILY PHYSICIAN: ____

I have read or have had explained to me the information in the important information statement about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.

SIGNATURE AUTHORIZING VACCINATION: __________________________ Date: __________

(Person receiving vaccination or guardian or parent making request.)

PATIENT RECEIVED NOPP FORM: Pt Initials (____________)

****

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THIS FORM.

DO NOT WRITE BELOW THIS LINE

****

DISCOUNT DRUG MART - STORE # _____________ DATE ADMINISTERED: _______________

VACCINE MANUFACTURER: **(Circle one)** Aventis Pasteur Novartis **CSL** MedImmune **Glaxo**

LOT #: ____________ DOSE: 0.5 ml NOTES: _____________________________

INJECTION SITE/GAUGE/LENGTH: L. Arm R. Arm 25 G 1 in 25G 5/8 in **Other**: _________________

Vaccine Administrator: Signature: ____________________ Title: ___________________________

ENTER INTO CONDOR BY USING THE E-RX OR OTHER BILLING CODES. KEEP FORM AT STORE