Influenza Immunization

Please fill out both sides of form.
Bring this form and your Primary Medical Insurance card to your appointment.

YOUR INFORMATION: PLEASE PRINT LEGIBLY

NAME ____________________ BIRTH DATE __________

ADDRESS ______________________________

CITY ____________________ ZIP CODE __________

PHONE NUMBER ____________________

PHYSICIAN INFORMATION: PLEASE PRINT LEGIBLY

NAME ____________________

PATIENT SIGNATURE:
(Authorization to receive vaccination and to bill your Medical Insurance on your behalf.)

SIGN ____________________ DATE __________

PLEASE CIRCLE YOUR PRIMARY MEDICAL INSURANCE:

Medicare	Advantra Freedom	MediGold
SummaCare	Pyramid Life Insurance/Rx Options	Humana Medicare
Secure Horizons	HomeTown Health Plan (SecureCare)	PrimeTime
Aetna Medicare	Anthem Senior Advantage	

INSURANCE CARD ID NUMBER: ____________________

PHARMACY STAFF USE ONLY:

Fluvirin by Novartis/Afluria by Merck
VACCINE MANUFACTURER

0.5 ml injected IM into Left ☐ Right ☐ arm, 25GI" 25G 5/8"

SIGNATURE OF VACCINE ADMINISTRATOR ____________________ DATE __________

VACCINE LOT NUMBER ____________________

According to the Ohio Board of Pharmacy's Protocol, this form must be completed so we can give you a flu vaccination.

1. Did you have a flu vaccine last year? Yes ☐ No ☐
2. Are you sick today? Yes ☐ No ☐
3. Do you have allergies to medications, eggs or any vaccine component? Yes ☐ No ☐
4. Have you ever had a serious reaction after receiving a vaccination? Yes ☐ No ☐
5. 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 ☐ No ☐
6. Do you, any person who lives with you, or any person you take care of, take Cortisone, Prednisone, or other steroids, anticancer drugs or x-ray treatments? Yes ☐ No ☐
7. During the past year, have you received a transfusion of blood or plasma, or been given a medicine called Immune Globulin? Yes ☐ No ☐
8. For women: Is it possible that you are pregnant or may become pregnant in the next three months? (Influenza vaccinations are recommended in pregnancy) Yes ☐ No ☐

INFLUENZA VACCINE ADMINISTRATION RECORD

I have read the information provided to me about influenza vaccine and any questions I may have had, have been answered by the Pharmacists administering the vaccine. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named for whom I am authorized to make this request.

MUST COMPLETE FORM ON REVERSE SIDE...