

Influenza Immunization

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

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

- 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, including Guillain-Barre Syndrome? 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

YOUR INFORMATION: PLEASE PRINT LEGIBLY

_____		_____	
NAME		BIRTH DATE	
_____		_____	
ADDRESS		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
_____		_____	
CITY		ZIP CODE	
_____		_____	
PHONE NUMBER		EMAIL ADDRESS	

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:

Fluzone by Sanofi Pasteur					
VACCINE MANUFACTURER					
0.5 ml injected IM into	Left <input type="checkbox"/>	Right <input type="checkbox"/>	arm,	25GI"	25G 5/8"
_____ SIGNATURE OF VACCINE ADMINISTRATOR			_____ DATE		
_____ VACCINE LOT NUMBER					

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...