Williams Bros. Health Care Pharmacy

Influenza Vaccine Screening Questionnaire, Consent and Administration Record

Patient Name: _____ Birth Date: _____

Address: _____

Insurance Type: _____ Policy #: _____

Primary Care Physician: _____ Phone: _____ Town: _____

Mother's Maiden Name: _____

For patients: The following questions will help us determine if you may be given the influenza vaccine 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.

	Yes	**No**	**Don't Know**
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
• Do you have allergies to eggs?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Have you ever had Guillain-Barré syndrome?	☐	☐	☐

Requested Vaccine: Influenza Vaccine

I attest that the above answers are correct, to the best of my knowledge. I also have had the opportunity to review the vaccine information statement and consent to receive the requested vaccine.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Form reviewed by: _____ Date: _____

***** Pharmacy Use Only Below *****

Vaccine	**Type of Vaccine**	**Date given** (mo/day/yr)	**Site***	**Vaccine**		**Vaccine Information Statement (VIS)**		**Vaccinator** (signature & title)
				Lot #	Mfr.	Date on VIS	Date given	
Influenza (IIV3, IIV4)								

*Site: RA = Right Arm; LA = Left Arm