FLU SHOT CONSENT FORM

I have read or have had explained to me the information on the "Influenza Vaccine: What You Need to Know" fact sheet dated 08/06/2021. I have had the chance to ask questions that were answered to my satisfaction. I have answered the Screening Questionnaire for Injectable Influenza Vaccination truthfully and to the best of my ability. I believe I understand the benefits and risks of the 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.

Name_______________________________Date of Birth_______________

Mailing address____

Telephone/Cell:__________________________Email:_________________

Signature__________________________________Date_______________

For billing purposes, attach front and back photocopy of insurance card or complete below information. Make sure your information is current. Only enter prescription coverage insurance information that you may have.

Note: We cannot bill to Cigna insurance. You may receive a vaccine however we would need to charge you a cash price and you may then submit it to your insurance company.

PLEASE PRINT CLEARLY!

Over 65 years, Medicare # (not your social security #)____________________

Insurance ID #:__________________________Group #_________________

Bin#___________________________________PCN#____________________

Insurance Co. Name & Telephone # ________________________________

_________________ Pharmacy will report to your Primary Care Provider and Vermont Immunization Registry the details of your vaccine, so please complete the following information clearly:

Provider Name:____________________Practice Name:__________________

FAX NUMBER:_________________

DO NOT COMPLETE BELOW UNTIL CLINIC DAY
YOU MAY COMPLETE ON CLINIC DAY PRIOR TO ARRIVING

Name________________________________DOB____/____/_____

COVID-19 QUESTIONS

1. **Have you had any of the following symptoms in the last 14 days. Please circle if yes.**

   Fever, shortness of breath, fatigue, muscle pains, headache,

   new loss of smell or taste, sore throat, congestions or runny nose,

   nausea, vomiting, diarrhea

2. **Have you had close contact with or cared for a person with confirmed or presumed COVID-19 in the last 14 days? Please circle YES or NO**

3. **Have you tested positive for COVID-19 in the last 14 days? Please circle YES or NO**

Screening Questionnaire for Injectable Influenza Vaccination

For adult patients to be vaccinated: The following questions will help us determine if there is any reason, we should not give you injectable influenza vaccination 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.

	No	Yes	Do not Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to any component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Have you ever had a seizure or brain/nervous system problem?	☐	☐	☐

Vaccine Administered by _____________________ Pharmacy (802) ___-____

Date Vaccine Administered_______________________ Site of injection: Right Arm Left Arm

Quadrivalent **High Dose**

INFLUENZA VACCINE Manufacturer: _______________Lot #__________Exp Date_______

NDC #____________________

Signature and title of person administering vaccine:

Signature:____RPh/RN______________________________