GREENHILL PHARMACY

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Patient Name:______________________________ Date of Birth: ___/___/___
(mm) (dd) (yr)

Phone Number:____________________

Address: ______________________________ City, State, Zip ____________________

Patient Social Security Number or Medicare Number : ______________________________

Insurance__________RX Bin#______RX PCN# _______RX GROUP#_________ID#____________________

Screening Questionnaire for Inactivated 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 inactivated 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.

1. Is the person to be vaccinated sick today? ☐ YES ☐ NO
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? ☐ YES ☐ NO
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ YES ☐ NO
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? ☐ YES ☐ NO

Patient Signature : ______________________________ Date: ______________

(Parent Signature and Consent if patient is under 18 years of age)

To be completed by Pharmacist

Influenza Vaccine

Administration Date ______________________________

Administration Site ☐ Left Arm ☐ Right Arm

Dosage ☐ 0.5ml ☐ 2.5ml ☐ LAIV

Manufacturer & Lot Number ______________________________

VIS Date ______________________________

Pharmacist's Signature: ______________________________ Date: ______________