Center Drug

PATIENT INFLUENZA VACCINE REGISTRATION FORM:

Circle Shot requested: Regular Quad Dose High Dose (for 65+ years)

Today's date:_____Medicare #:_____

Patient Name_____

Date of Birth:____/____/____Age:_____Sex: M F Phone:_____

Address:_____

City:_____State:_____Zip:_____

Current Insurance Information (all of this information can be found on your drug insurance card):

Rx Bin:_____

Rx PCN:_____

Rx Group:_____

Rx ID Number:_____

Emergency Contact:

Name:_____Phone:_____

The above information is true to the best of my knowledge. I authorize Hopkins Center Drug to bill my Health Plan or other payers on my behalf, and to receive payment of authorized benefits. I agree that it is my responsibility to pay for any health care services not covered by my Health Plan including copayments, deductibles and co-insurance.

Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers. If you decide not to have the information shared with MIIC, please call 1-800-657-3970.

_____ _____

Patient or Legal Guardian Signature **Date**

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____/____/____ (month / day / year)

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) 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. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Vaccine: Flucelvax Quad by Seqirus Fluzone HD Quad by Sanofi Pasteur

Fluzone Quad by Sanofi Pasteur Afluria Quad by Seqirus

Dose: 0.5ml 0.7ml

Lot #:_____ Exp. Date:_____

Route: IM Site: Left Deltoid Right Deltoid

VIS Date: 8/6/2021

Date Vaccine & VIS given:_____

Vaccinator:_____