Save time and complete the ***Patient Information*** portion of our Flu **Administration Record** and the ***entire*** **Questionnaire** in advance. Please print it and bring it with you to the pharmacy when you stop by for your flu shot.

2015-2016 INFLUENZA VACCINE - ADMINISTRATION RECORD

METHOD OF PAYMENT: [ ] **CASH** [ ] **PRESCRIPTION PLAN (PHARMACY BENEFIT)** [ ] **MAJOR MEDICAL**

[ ] **MEDICARE "B" (E-RX) MEDICARE #:** ______________________________

OR

[ ] **MEDICARE REPLACEMENT (ALL) or**

[ ] **PRIVATE INSURANCE/MAJOR MEDICAL (CIGNA, MEDICAL MUTUAL and SUMMA ONLY)**

* Provide Insurance Card for Verification*

PLAN NAME: ______________________________

CLAIM ADDRESS: ______________________________

ID#: ______________________ **GROUP#:** ______________________

RELATIONSHIP TO CARD HOLDER (Circle one): **HOLDER** **SPOUSE** **DEPENDENT**

For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart. If a claim rejects, we will charge cash. For patient reimbursement, the patient must submit their Cash Receipt to their major medical benefits provider.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)			
(Name) Last:	**First:**		**Middle Initial:**
Address:	**Phone:**	**Birthdate:**	**Gender: M F** **Age: Weight:**
City:	**State:**	**Zip:**	**County:**
Allergies:		**Chronic Illness: Yes [ ] No [ ]**	
Physician Name:		**Address:**	

Amount being submitted on your behalf (estimate only*):
Flu Vaccine (TIV) + Administration of Vaccine - $30.00*
Flu Vaccine (QIV) + Administration of Vaccine - $40.00*
FluMist + Administration of Vaccine - $45.00*
Fluzone HD + Administration of Vaccine - $55.00*

Physician On Record:
Joyce Lender
1268 East Broad St., Suite #1
Elyria, Ohio 44035

I have read or have had explained to me the information in the Vaccine Information Statement about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of 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. I have received the VIS Form and the Discount Drug Mart NOPP.

SIGNATURE AUTHORIZING VACCINATION: ______________________________ **Date:** ____________

[Person to receive vaccine or person authorized to make request (parent or legal guardian)]

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THIS FORM

****

******DO NOT WRITE BELOW THIS LINE******

****

DISCOUNT DRUG MART - STORE # ____________ DATE ADMINISTERED: ______________________

VACCINE NAME/MFG: **Afluria/CSL** **Fluvirin/Novartis** **Flulaval/GSK** **FluMist/MedImmune** **FluzoneHD/Sanofi**

LOT and EXP: ________________ DOSE/ROUTE: 0.5 mL/IM 0.2mL/intranasal 0.1mL/intranasal

INJECTION SITE/NEEDLE GAUGE-LENGTH: L Arm R Arm / 25G 1in 25G 5/8in Other: ________________

Vaccine Administrator: Signature/Title: ____________________ Printed Name: ____________________

SCAN (DOUBLE SIDED) **<u>COMPLETED</u>** **ADMINISTRATION RECORD AS THE** **<u>RX</u>** **IMAGE. KEEP THE HARDCOPY AT STORE LEVEL. ALSO SCAN (DOUBLE SIDED) THE INSURANCE CARD ASSOCIATED WITH THE CLAIM ON THE** **<u>THIRD PARTY RECORD</u>** **IN PRx.**

Patient Name:____

Today's Date:___________________________ Date of Birth:___________________________

Screening Questionnaire for Influenza Immunizations

This form helps us to decide which vaccines should be given in the pharmacy today. Please answer the following questions. Please see the pharmacist when completed.

1. Did you have a flu vaccine last year? — Yes or No

2. Are you sick today? — Yes or No
(If you are currently sick enough to go to the doctor or emergency room, you should postpone receiving a flu vaccine.)

3. Do you have allergies to medications? — Yes or No

4. Do you have allergies to eggs, any vaccine component? — Yes or No

5. Have you ever had a serious reaction after receiving a vaccine? — Yes or No

6. 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 or No
(Answering "Yes" is an extra reason to receive a flu vaccine.)

7. Do you, any person who lives with you or any person you take care of, take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments? — Yes or No
(Answering "Yes" is an extra reason to receive a flu vaccine.)

8. During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin? — Yes or No

9. For women: Is it possible that you are pregnant or may become pregnant in the next three months? — Yes or No
(Note: Influenza vaccines are recommended in pregnancy)