

# Screening Questionnaire for Injectable Influenza Vaccination

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Doctor/Clinic Name \_\_\_\_\_ Doctor Location \_\_\_\_\_

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to any foods, medications or vaccines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction after a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the person to be vaccinated have any health problems, like heart disease, diabetes, lung disease, asthma, kidney disease, anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form Completed By \_\_\_\_\_ Date \_\_\_\_\_

I Authorize Kemper Drug to administer the vaccine and to bill my insurance company for this service.

I understand that if I have a copay or the vaccine is not covered under my insurance policy I will be responsible for the copayment or cost for this service.

\_\_\_\_\_  
*Signature*

Vaccine Lot# \_\_\_\_\_

Vaccine Expiration Date \_\_\_\_\_

Form Reviewed By \_\_\_\_\_ Pharmacist or Nurse Date \_\_\_\_\_

Kemper Drug, 323 Jackson Ave, Elk River, Mn 55330

Received VIS for Inactivated Influenza Vaccine (08/10/10)

Insurance Information  Paid Cash  Billed through HCC  Billed Manually

Cardholder Name \_\_\_\_\_ Cardholder Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Id Number \_\_\_\_\_ Group Number \_\_\_\_\_

(Photocopy of Insurance Card Attached If Patient not already in Database)

Medical Billing (not pharmacy) Insurance Contact Phone Number on Back of Card

\_\_\_\_\_

Provider Faxed Immunization Data

or

Vaccine Information Entered in MIIC