

Screening Questionnaire for Inactivated 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 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?	<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. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<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

Fluzone 2011-2012 Sanofi
49281-388-15 0.5ml IM
Lot UH454AA Exp June 30,12
Deltoid L _____ R _____
Date _____ Initials _____

Form Reviewed By _____ RPh PharmD RN LPN Other _____ Date _____

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

Received VIS for Inactivated Influenza Vaccine (07/26/11 interim)

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