

**Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination**

Patient name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth\_\_ /\_\_ /\_\_\_\_

Address (*include zip code*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cardholder(*name if not patient)*\_\_\_\_\_\_\_\_\_spouse child (*circle one)*

**For patients (both children and adults) to be vaccinated:**

YES NO DON’T KNOW

|  |  |
| --- | --- |
| Is the person to be vaccinated sick today? □ □ □ | |
| Does the person to be vaccinated have an allergy to any component □ □ □  of the vaccine? | |
| Has the person to be vaccinated ever had a serious reaction □ □ □  to influenza vaccine in the past? | |
| Has the person to be vaccinated ever had Guillain-Barré syndrome? □ □ □ | |
| Does the person to be vaccinated have any drug allergies? □ □ □ | |

Who is your primary health care provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR SERVICES and MEDICAL RECORDS INFORMATION CONSENT FOR SERVICES**: I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

**AUTHORIZATION TO REQUEST PAYMENT**: I do hereby authorize Yorktown Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare or other insurance plan is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

**HIPAA AUTHORIZATION:** I voluntarily authorize and direct my health care provider at Yorktown Pharmacy to use and to disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Yorktown Pharmacy Vincent Thompson, MD(standing order provider, my Primary Care Physician, my insurance plan, health systems and hospitals, and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance) during the term of this HIPAA Authorization (“Authorization”). This Authorization permits Yorktown Pharmacy to disclose only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health information is disclosed to the recipients identified above. Yorktown Pharmacy cannot guarantee that any recipient will not redisclose my health information to a third party that may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by Yorktown Pharmacy. I understand that this Authorization will remain in effect until the term of this Authorization expires as noted above or I provide a written notice of revocation to Yorktown Pharmacy to the address provided in the Yorktown Pharmacy Notice of Privacy Practices. The revocation will be effective immediately upon Yorktown Pharmacy’s receipt of my written notice, except that the revocation will not have any effect on any action taken by Yorktown Pharmacy in reliance on this Authorization before it received my written notice of revocation.

*X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)*

Technical content reviewed by the

Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 •

www.immunize.org/catg.d/p4066.pdf

• Item #P4066 (9/17)

*To be completed by pharmacist:*

date VIS(pub 8-7-15) and vaccine provided\_\_\_10/08/18\_\_\_ injection site (*circle one)* RD/IM LD/IM

name of vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot #\_\_\_\_\_\_\_\_\_\_\_\_ exp\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

form reviewed and vaccine administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_