Immunization Administration Record

Influenza (Inactivated) Vaccine

First Name:		Last Name:	
Address:			
City:		State:	Zip:
Home Phone:		Cell Phone:	
DOB:	Age: (YRS)	□ M □ F	Weight: (LB)
Primary Care Physician (PCP) First Name:		PCP Last Name:	
PCP Address:			
PCP Phone:		PCP Fax:	

Indications: Please check "yes" or "no" for each question.		Yes	No	Notes
1.	For children 8 years of age and younger: Have you previously received at least TWO doses of flu vaccine? If yes, when?			
Precautions and Contraindications: *Please check "yes" or "no" for each question.*		**Yes**	**No**	**Notes**
2.	Are you sick today? *Immunizer to record patient temperature*			Temp:
3.	In the past month, have you been in contact with someone who has confirmed or suspected Coronavirus/COVID-19?			
4.	Over the last 14 days, have you had any of the following symptoms: cough, fever, loss of smell or taste, shortness of breath, or chills?			
5.	Do you have allergies to food (EX: EGGS), medications, a vaccine component, or latex?			
6.	Have you ever had a serious reaction after receiving a vaccination?			
7.	Have you ever had Guillain-Barre syndrome?			

Talk to the pharmacist before receiving this vaccine to review the above questions.

Co-administration Screening: *Please check "yes" or "no" for each question.*		Yes	No	Notes
8.	Have you previously received the pneumonia vaccine?			
9.	Have you previously received the zoster (shingles) vaccine?			
10.	Have you previously received the tetanus and whooping cough vaccine?			

Consent for services, medical records, and HIPAA privacy information

Medicare/Medigap Policy Holders:

I request that the payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Giant Eagle Pharmacy for any services furnished to me by Giant Eagle Pharmacy. I authorize the release of any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents, any information necessary to determine these benefits or benefits payable for related services.

All Patients:

I consent to receipt of the services indicated hereon and authorize Giant Eagle to release my immunization records to Federal and state immunization registries, my physician, and health insurance provider. I understand that I may receive follow-up communications from these entities as a result of this reporting.

I have received the Vaccine Information Sheet (VIS) associated with the vaccine described above. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc. and its respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with, or in any way related to, my receipt of this or these immunization(s). Giant Eagle, Inc. and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administrator of the vaccines described above. I acknowledge receipt of Giant Eagle's Notice of Pharmacy Privacy Practices.

Initial: ________ Medicare is my primary medical coverage, or I will be responsible for payment.

Please indicate Medicare number here:____

Initial: _______ I agree to be responsible for payment to Giant Eagle if my insurance plan does not cover the cost of this vaccination.

Signature (Patient or Legal Guardian): ____Date:_____________________

Print Name: ____

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Influenza (Inactivated) Vaccine

Healthcare Provider Only

Patient Name:	DOB:

By signing below, I agree that as the immunizing healthcare professional:

- I reviewed the patient's information and screening question responses.
- This vaccine is appropriate for this patient based on the responses to the screening questions and age guidelines according to ACIP recommendations, Giant Eagle's current vaccine protocols, and state regulations.

Signature (Immunizer):____ Date:_____________________________

Print Name (Immunizer):____Title (Immunizer):___________________

If Pharmacy Intern, print name of overseeing Pharmacist: ____

Vaccine (Mfgr):		**Dose:**
□ **Fluad QIV PFS (Seqirus) 0.5 mL**	□ **Flublok QIV PFS (Protein Sciences) 0.5 mL**	**Lot Number:**
□ **Fluarix QIV PFS (GSK) 0.5 mL**	□ **Fluzone QIV MDV (Sanofi Pasteur) 0.5 mL**	**Expiration Date:**
□ **Flucelvax QIV MDV (Seqirus) 0.5 mL**	□ **Fluzone QIV PFS (Sanofi Pasteur) 0.5 mL**	**VIS Date:**
□ **Flucelvax QIV PFS (Seqirus) 0.5 mL**	□ **Fluzone HD PFS (Sanofi Pasteur) 0.7mL**	**Site:** □ **Left Deltoid** □ **Right Deltoid**

Screening Questions Reference

Question	Response	Guidance **Depending on state specific guidelines**
1.	Yes/No	Patients 8 years of age and younger may need 1 or 2 doses of flu vaccine. If previous flu vaccination history is unknown: Administer 2 flu shots at least 4 weeks apart If they HAVE NOT received at least 2 flu shots total in their lifetime: Administer 2 flu shots at least 4 weeks apart If they HAVE received at least 2 flu shots total in their lifetime: Administer 1 flu shot
2.	Yes	As a precaution with moderate or severe acute illness, all vaccines should be postponed until the illness has improved. Mild illnesses (upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics. Measure the patient's temperature to screen for fever (defined as ≥100.0 °F per CDC guidance 6/20/20). Evaluate any reported symptoms that may be due to COVID-19.
3.	Yes	Vaccine should be postponed until it's been determined that the patient no longer poses a coronavirus transmission risk.
4.	Yes	The vaccine should be postponed until the patient has been symptom free for at least 14 days.
5.	Yes	DO NOT administer the vaccine to patients with a known life-threatening hypersensitivity reaction to any component of the vaccine. Check supplies for latex. If EGG allergy, please refer to the below on when to recommend egg free vaccine: • Persons who report having had reactions to egg involving symptoms, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or another emergency medical intervention, should receive an egg-free flu vaccine formulation unless referred to a physician's office or clinic for vaccination. • A previous severe allergic reaction to influenza vaccine, regardless of the component suspected of being responsible for the reaction, is a contraindication to future receipt of the vaccine.

VACCINE	AGE	EGG	THIMEROSAL	LATEX	ANTIBIOTICS	OTHER MEDS
FLUARIX QIV PFS	IN: 3+ with RX and 11+ under protocol; MD: 9+; OH: 7+; PA: 3+; WV: 11-17 with RX and 18+ under protocol	Yes	No	No	Gentamicin	Hydrocortisone
FLUZONE QIV MDV		Yes	Yes	No	No	No
FLUZONE QIV PFS		Yes	No	No	No	No
FLUCELVAX QIV MDV	IN: 4+ with RX and 11+ under protocol; MD: 9+; OH: 7+; PA: 4+; WV: 11-17 with RX and 18+ under protocol	No	Yes	No	No	No
FLUCELVAX QIV PFS		No	No	No	No	No
FLUBLOK QIV PFS	All states: 18+	No	No	No	No	No
FLUAD QIV PFS	All states: 65+	Yes	No	No	Neomycin, Kanamycin	Hydrocortisone
FLUZONE HD QIV PFS	All states: 65+	Yes	No	No	No	No

Question	Response	Guidance
6.	Yes	Gather information from patient on any serious reactions that occurred following previous vaccinations to determine if the patient should receive this vaccine.
7.	Yes	If GBS occurred within 6 weeks of receipt of a prior influenza vaccine, the risk for Guillain-Barre syndrome may be increased following vaccination. If patient reports GBS, refer patient to physician for further evaluation on appropriateness of receiving the vaccine.
8, 9, 10.	Yes/No	Review patient's history for eligibility for these immunizations.

Last reviewed: 8/7/20 CG