M&S PHARMACY

FLU SHOT SCREENING AND CONSENT FORM

Last Name:		First Name:		
Mailing Address:	City:		State:	Zip:
Contact Phone:		Gender:	DOB:	Age:
Primary Care Physician:			PCP Fax:	

Insurance Provider:		ID Number:
BIN:	Group:	PCN:

SCREENING QUESTIONAIRE

	Yes	No
1. Do you feel sick or have a fever today?		
2. Have you ever had a serious reaction to any vaccine including the flu vaccine?		
3. Have you had any other vaccines in the last 4 weeks?		
4. Do you have any allergies to eggs, latex, vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast or yeast)?		
5. Do you have a chronic health condition such as: *heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes), asthma, or a blood disorder*?		
6. Have you ever had a seizure disorder for which the patient is on seizure medication(s), a brain disorder, Guillain- Barré Syndrome (a condition that causes paralysis) or other nervous system problem within 6 weeks of receiving the flu vaccine?		
7. *For women*: Are you pregnant or considering becoming pregnant in the next month?		

Patient/Parent Signature:______________________________________ Date:___________

BELOW TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY			
NDC:		LOT:	MANUFACTURER:
EXP DATE:	VIS DATE: 08/06/2021	SITE: LA RA	DOSE: 0.5 mL
PHARMACIST SIGNATURE:			DATE: 10/06/2022

Must fax to **Dr. Stephanie Han (Fax: 678-221-5814)** within 24 hours of admin & to PCP within 7 days.

By Signing: I certify that I am the patient and at least 18 years of age or the legal guardian of the patient. Furthermore, I give the consent to the healthcare provider at M&S pharmacy to administer vaccines at my request. I understand the risk and benefits of the vaccine and have received the Vaccine Information Statement and have had all my questions and concerns answered.