Patient Consent Form and Screening Questionnaire for Immunization
2023-2024 Quadrivalent Influenza Vaccine

Section I. Personal Information

First Name			Last Name	
DOB	Age	Gender	Marital Status	Mother's Maiden Name
Home Address			City, State, ZIP, County	
Telephone □ Mobile □ Landline			Parent/Guardian/Surrogate	
Medicare Number			Primary Care Physician and Telephone Number	
Social Security Number or Primary Insurance BIN/Group/ID				

Section II. Questionnaire for Immunization

		Yes	No	Don't know
1	Do you feel sick or have a fever today?	□	□	□
2	Are you allergic to eggs, egg products, latex, neomycin, polymyxin, or gentamicin?	□	□	□
3	Have you ever had a serious reaction or fainted after receiving a vaccination in the past?	□	□	□
4	Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving an influenza vaccine?	□	□	□
5	Have you received any other vaccines within the last four weeks?	□	□	□
6	Are you currently taking aspirin, Coumadin, Plavix, Eliquis, Xarelto, or any other type of blood thinner or anticoagulant?	□	□	□
7	Have you taken an antiviral medication for the flu within the last 48 hours?	□	□	□
8	**For women:** Are you pregnant or are you planning on becoming pregnant?	□	□	□

(TURN ↷ OVER)

Section III. Influenza Vaccine Information

Inactivated (recombinant) quadrivalent influenza vaccine: this vaccine protects against four different influenza virus subtypes: two influenza A strains (one each of H_1N_1 and H_3N_2), and two influenza B strains. Because it is created from dead and inactivated viral components, this vaccine ***will not*** and ***can not*** give you the flu. Administration is into the upper deltoid muscle of the arm. Side effects are generally mild, and may include soreness, redness, itching, or swelling at the injection site. Fever, hoarseness, red or itchy eyes, drowsiness, headache, and muscle aches are also possible, though rare. These symptoms usually begin soon after the injection and may last for one to two days.

Annual influenza vaccination is the most important way of preventing seasonal influenza virus infections and potentially severe complications. Vaccination reduces the likelihood of becoming ill with influenza, transmitting influenza to others, and protecting other individuals within our community: those who are not vaccinated, those with compromised or underdeveloped immune systems, those with chronic illnesses at higher risk of serious complications due to the flu, and those who have received the vaccine but did not develop immunity. Please refer to the Vaccine Information Statement (VIS) for additional information.

Section IV. Signature

I understand the benefits and risks of the vaccination as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I hereby consent to the administration of the influenza vaccine. I have read the information on this form. I release and hold harmless Riverside Remedies Pharmacy, its pharmacists, staff, employees, volunteers, and any other persons involved, from any liability, damage, or claim arising from any injury or complications that may result from my participation in this vaccine program. I understand that the vaccine will not be fully effective for approximately two weeks, and as with all vaccines, there is no guarantee that I will become immune or will not experience side effects.

I have received a copy of the Privacy Practices and appropriate CDC Vaccine Information Statement (VIS). I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my information.

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Recipient/Parent/Surrogate/Guardian Signature Date/Time Relationship to patient, if other than recipient

TO BE COMPLETED BY PROVIDER				
Vaccine	**Manufacturer**	**Rx**	**Expiration Date**	**Lot Number**
Administration Site	**Valency**	**VIS Date**	**Type**	
□ R □ L Deltoid	□ IIV3 □ IIV4 □ LAIV	08/06/2021	□ TV □ QV □ PFS □ MDV	

□ I have reviewed side effects with the patient (and parent, guardian, or surrogate, as applicable), and I confirm that the patient (and their surrogate, if applicable), was given an opportunity to ask questions about the vaccination, and all the questions asked by them have been answered correctly and to the best of my ability.

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Vaccinator Signature