



EMPLOYER GROUP

Keanu HS.

(Circle one)

Rx# 24 | 26 | 30 | 32 | 37 | 38 | 43

Immunization Program Adult Screening Questionnaire/Consent/Release Form:

Patient's Last Name: (Print Clearly) _____ First: _____ Middle: _____ Female Birth Date: _____
 Male / /

Mailing Address: _____ City/State _____ Zip Code _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email Address: _____

PRIMARY INSURANCE	<input type="checkbox"/> HMSA	<input type="checkbox"/> TRICARE	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	Subscriber ID#:
	<input type="checkbox"/> KAISER	<input type="checkbox"/> HMA	<input type="checkbox"/> UHA	-NAME:	
	<input type="checkbox"/> HMAA	<input type="checkbox"/> UHC			

Patient's relationship to subscriber: Self Child Spouse Other _____ Subscriber Name responsible for bill (if different) _____ Birth Date: / /

SECONDARY INSURANCE	Name of Insurance:	Subscriber ID#:
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Patient's relationship to subscriber: Self Child Spouse Other _____ Subscriber Name responsible for bill (if different) _____ Birth Date: / /

I have read the above information and hereby affirm that all of the information I have provided on this form is true. I understand that it is my responsibility to seek the advice of a physician if I have checked (YES) to any of the qualifying questions listed in this form and/or have any doubts or concerns about my ability to receive this vaccine. I understand the risks and benefits of the vaccination that I am receiving, and that there may be additional unknown risks. I waive and release any and all rights and claims that I and/or my heirs have or may have against Foodland and/or Sullivan Family Co., its employees, agents, affiliates, and their representatives because of any injuries or illnesses suffered by me in connection with the administration of the vaccine/ injection. I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the undersigned physician or supplier for the vaccine/injection. INITIAL ____ I am financially responsible for appropriate deductibles, copayments, and non-covered items.

X _____
Patient Signature

X _____
Date

Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.		YES	NO
1	Do you have a history of Guillain-Barre Syndrome?		
2	Are you allergic to eggs, egg products, neomycin, polymixin or latex?		
3	Do you have a cold, fever or active illness?		
4	Have you ever had an allergic reaction to flu or other vaccine?		
5	For women: Are you pregnant or are you considering becoming pregnant?		

BELOW LINE FOR PHARMACY USE ONLY

Vaccine	Lot# of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection	VIS Date
Influenza (Seasonal)	300477	03/30/12	Fluzone Other: <u>Fluzone</u>	0.5mL	IM L / R Deltoid	

Signature of Pharmacist: _____ RPh Date VIS provided to patient: _____