CHUH SCHOOL DISTRICT INSTITUTE FLU CLINIC - ADMINISTRATION RECORD

METHOD OF PAYMENT: [ ] Medical Mutual of Ohio [ ] Cash-Invoice CHUH School District

[ ] MEDICARE "B" (E-RX) MEDICARE #: _____

[ ] MEDICARE REPLACEMENT (ALL)

[ ] PRIVATE INSURANCE/MAJOR MEDICAL (AETNA, CIGNA, MEDICAL MUTUAL, or SUMMA ONLY)

* Provide Insurance Card for Verification*

PLAN NAME: _____

ID#: _____ GROUP#: _____

RELATIONSHIP TO CARD HOLDER (Circle one): HOLDER SPOUSE DEPENDENT

For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart. If a claim rejects, we will charge cash. For patient reimbursement, the patient must submit their Cash Receipt to their major medical benefits provider.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)			
Last:	**First:**		**Middle Initial:**
Address:	**Phone:**	**Birthdate:**	**Gender:** **Age:** **Weight:**
City:	**State:**	**Zip:**	**County:**
Allergies:		**Chronic Illness: Yes [ ] No [ ]**	
Physician Name:		**Address:**	

Amount being submitted on your behalf (estimate only*):
Flu Vaccine (QIV) + Administration of Vaccine - $28.00*
Fluzone HD + Administration of Vaccine - $50.00*

Physician On Record:
Julia Bruner, MD MS

2500 MetroHealth Drive
Cleveland, Ohio 44109

I have read or have had explained to me the information in the Vaccine Information Statement about influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I agree to receive treatment for any adverse event that may occur after receiving the vaccine while on site. In the event of an accidental post vaccination needle stick to the vaccine administrator, I agree to be contacted for follow up lab work. I have received the VIS Form and the Discount Drug Mart NOPP.

SIGNATURE AUTHORIZING VACCINATION: _____ Date: _____

[Person to receive vaccine or person authorized to make request (parent or legal guardian)]

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE OF THIS FORM

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******DO NOT WRITE BELOW THIS LINE******

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DISCOUNT DRUG MART – FLU CLINIC: **CHUH School District** DATE ADMINISTERED: **11/5/2019**

VACCINE NAME/MFG: **Flulaval/GSK** **Fluzone HD/Sanofi**

LOT and EXP: _____ DOSE/ROUTE: **0.5 mL/IM**

INJECTION SITE: **L Arm** **R Arm** NEEDLE GAUGE/LENGTH: **25G 5/8 in** **25G 1in** **25G 1 ½ in**

Vaccine Administrator: Signature/Title: _____Printed Name: _____

SCAN (DOUBLE SIDED) COMPLETED ADMINISTRATION RECORD AS THE RX IMAGE. KEEP THE HARDCOPY AT STORE LEVEL. ALSO SCAN (DOUBLE SIDED) THE INSURANCE CARD ASSOCIATED WITH THE CLAIM ON THE THIRD PARTY RECORD IN PRx.

Patient Name:_____

Today's Date:_____ Date of Birth:_____

Screening Questionnaire for *Influenza* Immunizations

This form helps us to decide which vaccines should be given in the pharmacy today. Please answer the following questions.

1.	Did you receive a flu vaccine last year?	Yes or No
2.	Are you sick today? (If you are currently sick enough to go to the doctor or emergency room, you should postpone receiving a flu vaccine.)	Yes or No
3.	Do you have allergies to medications?	Yes or No
4.	Do you have allergies to eggs or any vaccine component?	Yes or No
5.	Have you ever had a serious reaction after receiving a vaccine?	Yes or No
6.	Do you, any person who lives with you, or any person you take care of, have cancer, leukemia, AIDS, or any other immune system problem? (Answering "Yes" is an extra reason to receive a flu vaccine.)	Yes or No
7.	Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments? (Answering "Yes" is an extra reason to receive a flu vaccine.)	Yes or No
8.	During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	Yes or No
9.	For women: Is it possible that you are pregnant or may become pregnant in the next three months? (Note: Influenza vaccines are recommended in pregnancy)	Yes or No
10.	Are you 50 years of age or older? a. If yes, have you received your shingles vaccine?	Yes or No Yes or No
11.	Have you completed your immunization review at Discount Drug Mart within the last year? (If No, we can start the quick and easy process today.)	Yes or No