EMPLOYER GROUP ______________________

(Circle one)
Rx# 24 | 26 | 28 | 30 | 32 | 37 | 38 | 43

Immunization Program Adult Screening Questionnaire/Consent/Release Form:

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

Mailing Address:	**City/State**	**Zip Code**

Home Phone: ( )	**Cell Phone:** ( )	**Work Phone:** ( )

Email Address:

PRIMARY INSURANCE	❑ **HMSA ID#:** ❑ **HMO** ❑ **PPO**	❑ **MEDICARE ID#:**	❑ **HMA ID#:**	❑ **HMAA ID#:**	❑ **UHA ID#:**

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

SECONDARY INSURANCE	❑ **HMSA ID#:** ❑ **HMO** ❑ **PPO**	❑ **MEDICARE ID#:**	❑ **HMA ID#:**	❑ **HMAA ID#:**	❑ **UHA ID#:**

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)			**Fluzone** **Other:**________	0.5mL	IM L / R Deltoid	

Signature of Pharmacist:______________________**RPh** **Date VIS provided to patient:**______________

(White Copy) Pharmacy Coordinator **(Yellow Copy) Pharmacy** **(Pink Copy) Patient**