HIGH DOSE (Fluzone HD QIV 65+) INFLUENZA IMMUNIZATION RECORD PLU 7979

Name_____Date of Birth_____Age_____Sex_____

Address_____City_____State_____Zip_____

Name of Doctor or Provider_____

Temperature: _____ Passed "COVID Screening" - Date _____Initials_____

Influenza screening questions: PLEASE CIRCLE

Do you have a history of an allergy to: eggs, egg products, mercury or thimerosal (preservative found in contact lens solution) If yes, please explain:_____	Yes	No	
Do you feel sick today OR have you been running a fever?	Yes	No	
Have you ever had a serious reaction to the flu vaccine or been diagnosed with Guillian-Barre Syndrome	Yes	No	Never had Flu Shot
Are you pregnant?	Yes	No	
Do you have a latex allergy?	Yes	No	N/A

I understand the benefits & risks of the influenza vaccine & request that it be given to me or to the person named below for whom I am authorized to make this request. I have been provided a copy of the Influenza Vaccine Information Sheet & am aware of any possible side effects. I hereby assume any risks related to receiving such shot & release Lewis Drug and its agents, staff, representatives, successors and assigns, and subrogates from any & all liability related, directly or indirectly, which may arise from having been given the flu shot. I am aware I am asked to wait for 15 minutes after receiving my vaccination. If I have received the vaccine in my vehicle or otherwise outside of the Lewis Drug facility, **I acknowledge that Lewis Drug has recommended that I park and wait for 15 minutes after vaccination to ensure I don't evidence any adverse reactions**.

I certify that the information given if applying for payment under Medicare/commercial insurance is correct. I authorize release for all required to act on this request. I request that payment of authorized benefits be made in my behalf; if claim is not approved by Medicare/commercial insurance, I understand that I will be responsible for the cost of the vaccine. I also acknowledge that my private health information will only be shared with others in the interest of treatment, payment, or other necessary healthcare operations, and by signing below; I accept the privacy act policies of this facility.

__ I do NOT wish to have my/my child's immunization record shared with other providers (South Dakota residents only)

Signature of person to receive vaccine/guardian if minor/person authorized to make the request:

X_____Date_____

----------For Office Use ----------

Date of Administration_____ Site: Lewis Drug #_____-or-_____

Site of Administration: L or R Deltoid Immunizer Signature_____

Manufacturer - Vaccine	Lot Number	Expiration Date	VIS Provided *Circle
Sanofi - Fluzone **HD** QIV PFS 20-21 49281-0120-88 CPT 90662			Version 2015 / 2019

Payment Method:

MEDICARE PART B# _____ Medicaid: _____ Cash Pay: Yes No

Commercial Insurance ID:_____BIN_____PCN_____Group_____

Admin Code : G0008 Dx Code : Z23 Claim BILLED : Yes No

FOR PHARMACISTS ONLY: Date sent to Physician_____ Pharmacy Phone Number_____

Date added to state immunization registry_____ Staff Initials _____

RETAIN RECORD FOR 5 YEARS