Bremo PHARMACY
LONG TERM CARE

*Service Beyond Comparison*
**www.BremoRX.com**

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# Influenza Screening 2025- 2026

Last Name:_____ First Name:_____ Middle Initial:__

DOB:_____/_____/_____ Age:_____yrs Gender: M F

Home Name:_____

Please answer the following questions:

| | | |
|---|---|---|
| IS THE PERSON TO BE VACCINATED SICK TODAY? | YES | NO |
| DOES THE PERSON HAVE AN ALLERGY TO EGGS, LATEX, OR GELATIN? | YES | NO |
| HAS THE PERSON EVER HAD AN ALLERGIC REACTION TO A VACCINE RESULTING IN MEDICAL CARE? | YES | NO |
| HAS THE PERSON HAD GUILLAN BARRE SYNDROME? | YES | NO |

**We offer insurance billing for Medicare. If you have traditional Medicare, enter ID below.**
**(If you are in an HMO Medicare plan, please show your ID card to the pharmacist)**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicare ID # | | | | | - | | | | - | | | | |

I have read, or had explained to me, the information about the influenza vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine marked above.

_____ _____

**Signature** **Date of vaccination**

| | | | | |
|---|---|---|---|---|
| Afluria | | | LA | RA |
| | | | | |
| Fluarix | JS74H | 6/30/26 | | |
| | | | | |
| Fluad (65+) | 407243 | 4/23/26 | | |
| | | | | |
| | | | | |
| Flumist | | | | |
| COVID | Moderna | Lot: | LA | RA |

Shingrix #___ (IM) lot/exp:
LA RA
Tdap (IM) lot/exp:
LA RA
Prevnar 20 (IM): lot/exp:
LA RA

VIS: Inactivated/live Influenza Vaccine (1/31/25), COVID (1/31/25) PCV (5/29/25) Zoster/Shingles (Recombinant 2/4/22), Tdap (1/31/25)
Cash: _____ Other/GH: _____
Initials: T. Kaefer_____, resident _____, J. Helmke_____, R. Richardson_____, B. Loehr _____ C. Cary_____, D. Fonner_____, L. Mascari_____, K. Kittinger_____, A. Davis_____, Other_____