

Influenza Screening 2026-2027

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 #					-				-				
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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

Fluzone	6UA4AU1G	6/30/27	LA	RA
Fluarix	FG32D	6/30/27		
Fluzone HD (65+)	6UA4NU1G	6/30/27		
Other:				
COVID	Moderna	Lot:	LA	RA

Shingrix # (IM) lot/exp:
 LA RA
 Tdap (IM) lot/exp:
 LA RA
 Prevnar 20 (IM): lot/exp:
 LA RA
 PCV 21 (IM): lot/exp:
 LA RA
 RSV (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 _____