☐ Medicare # _____ ☐ Cash
☐ Insurance Carrier name _____Group # _____ID#_____

South Carolina Injectable Influenza Screening Questionnaire and Consent Form

Patient Information: (Patient to complete)

*Patient Name: _____*Date of Birth: _____ *Age: _____ *Phone# _____

*Address: _____ *City: _____ *State: _____ *Zip:_____

*Gender: M or F *Which vaccine(s) would you like to receive today? _____

*Medical Conditions: _____ *Enter Weight if less than 110 lbs: _____
FOR EMERGENCY USE ONLY

*Primary Doctor: _____ *Dr. Phone: _____

* Alt Doctor: _____ *Dr. Phone: _____

Email Address _____
By providing your email address you are agreeing to receive special offers, discount and information via email from Rite Aid. You may opt out of the email communications at any time. Rite Aid values your privacy. As a result, we will never share or sell your information with any outside manufacturers or marketers.

The following questions shall be used to determine if there is any reason an inactivated injectable influenza vaccination should not be given:

Screening Questions for the Injectable Flu Vaccine:	Yes	No	Don't Know
Are you 18 years of age or older?			
Are you sick today?			
Do you have an allergy to eggs or to a component of the vaccine?			
Have you had a serious reaction to an influenza vaccine in the past?			
Have you ever been diagnosed as having Guillain-Barre syndrome?			
Did you bring your Immunization Record Card with you?			
Have you had the following vaccines:	**Yes**	**No**	**Don't Know**
• **Pneumococcal Vaccine**			
• **Shingles Vaccine**			
• **Whooping Cough (Tdap) Vaccine**			

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Rite Aid.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 20 minutes, after the administration of the immunization.
- I acknowledge receipt of Rite Aid's Notice of Privacy Practices for Protected Health Information.
- I have read, or had explained to me, the Vaccine Information Statement for influenza vaccine. I understand the risks and benefits, and have been provided an opportunity to ask questions, and they have been answered to my satisfaction *and understand the b*enef*its and risks of the vaccine(s).*
- I wish to receive the influenza vaccine and hereby give consent for the pharmacist to administer the influenza vaccine and communicate the administration of the vaccine to my primary care practitioner, who is listed above.
- I fully release and discharge Rite Aid Corporation, its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature (If under the age of 18: Parent/legal guardian signature)**:** _____ **Date** _____

Pharmacy Use Only

Place RX Label Here

Injectable Influenza VIS Date: _____

Lot # _____

Exp Date: _____

Site LA or RA (Circle one)

Signature of pharmacist who administered Vaccine(s): _____ License #: _____ Date: _____
