giant eagle pharmacy

Immunization Administration Record

Influenza (Inactivated) Vaccine

First Name:	Last Name:		□ Male □ Female
Address:	City:	State:	Zip:
Phone:	Social Security Number:		
Birthdate:	Age: (YRS)	Weight:	(LB)
Primary Care Physician (PCP) First Name:	PCP Last Name:		
PCP Address:	City:		State:
PCP Phone #:	PCP Fax #:		
For Clinics Only: Insurance:	Group:	ID #:	
For Clinics Only: Insurance:	Group:	ID #:	
For Clinics Only: GEAC #: 4		□ GEAC Scanned	□ Look up GEAC

	Indications: *Please check "yes" or "no" for each question.*	**Yes**	**No**
1.	For children 8 years of age and younger: Have you previously received at least TWO doses of flu vaccine? When?		
	Precautions and Contraindications: *Please check "yes" or "no" for each question.*	**Yes**	**No**
2.	Are you feeling sick today?		
3.	In the past 14 days, have you been in contact with someone who has confirmed or suspected COVID-19?		
4.	In the past 10 days, have you had any of the following symptoms: cough, fever, loss of smell or taste, shortness of breath, chills, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
5.	In the past 10 days, have you had a positive test or doctor's diagnosis for COVID-19?		
6.	Do you have allergies to food (EX: EGGS), medications, a vaccine component, or latex?		
7.	Have you ever had a serious reaction after receiving a vaccination?		
8.	Have you ever had Guillain-Barre syndrome?		

Talk to the pharmacist before receiving this vaccine to review the above questions.

Consent for Services, medical records, and HIPAA privacy information

Medicare/Medigap Policy Holders: I request and assign payment of authorized Medicare and/or Medigap benefits, as applicable, to be made on my behalf to Giant Eagle Pharmacy for any products or services furnished by them to me. I authorize the release of medical information about me to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents as necessary to determine benefits payable for these or related services.

All Patients: I acknowledge receipt of Giant Eagle's Notice of Privacy Practices and authorize the release of immunization information to Federal and state authorities and to any covering health insurance provider(s). For the vaccine(s) indicated hereon, I acknowledge receipt of the relevant Vaccine Information Sheet (VIS) or EUA Fact Sheet. I affirm that I have had the opportunity to ask questions and that I voluntarily assume full responsibility for any reactions that may result. I request administration of the immunization(s) to me or to the patient identified hereon for whom I am the legal guardian. I, for myself, my wards, heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc., the hosting facility and its managing and operating companies and owners, the event sponsors, and each entity's respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with, or in any way related to, the receipt or administration of the immunization(s) indicated hereon. Further, I affirm that I request and access these services at my own risk and will not hold the aforementioned parties, to any extent whatsoever, liable, responsible, or in any way accountable for any loss, physical or personal injury, death, or damages suffered or sustained at any time in connection with or as a result of their offering of this vaccine program, the administration or receipt of the vaccines requested, or access to or use of the hosting facilities.

Initial: _____ I agree to be responsible for payment to Giant Eagle if my insurance plan does not cover the cost of this vaccination.

Signature (Patient or Parent/Legal Guardian): _____

Print Full Legal Name (Patient or Parent/Legal Guardian): _____ Date:_____

For School Clinics Only: My signature above indicates that I understand that if this release is executed in support of a school-sponsored immunization program, I consent to the person named above, for whom I am a parent or legal guardian, receiving the applicable immunization without me being present on the clinic date of : _____.

Healthcare Provider Only

By signing below, I agree that as the immunizing healthcare professional: I reviewed the patient's information and screening question responses. This vaccine is appropriate for this patient based on the responses to the screening questions and age guidelines according to ACIP recommendations, Giant Eagle's current vaccine protocols, and state regulations. Appropriate written education has been provided to the patient, including a Well Child Visit Reminder as applicable.

Signature (Immunizer): _____Date:_____

Print Name (Immunizer):_____Title (Immunizer):_____

If Pharmacy Intern, overseeing Pharmacist to sign and print name: _____

Vaccine:		**Lot Number:**
□ **Fluad QIV PFS (Seqirus) 0.5 mL**	□ **Flulaval QIV PFS (GSK) 0.5 mL**	**Expiration Date:**
□ **Fluarix QIV PFS (GSK) 0.5 mL**	□ **Fluzone QIV MDV (Sanofi Pasteur) 0.5 mL**	**Clinic:**
□ **Flucelvax QIV MDV (Seqirus) 0.5 mL**	□ **Fluzone QIV PFS (Sanofi Pasteur) 0.5 mL**	**VIS Date:**
□ **Flucelvax QIV PFS (Seqirus) 0.5 mL**	□ **Fluzone HD PFS (Sanofi Pasteur) 0.7mL**	**Ordering Provider:**
Sig: Administer 1 shot intramuscularly into the:	□ **Left Deltoid** □ **Right Deltoid**	**No Refills**