giant eagle pharmacy

Immunization Administration Record

Influenza Vaccine

First Name:		Last Name:	
Birthdate:	Age:	Weight:	Sex assigned at birth: ○ Male ○ Female
Address:		City:	State: Zip:
Phone:		Last 4 digits of Social Security Number:	
Primary Care Physician (PCP) First Name:		PCP Last Name:	
PCP Address:			
PCP Phone:		PCP Fax:	

Insurance:	Group:	ID #:
Insurance:	Group:	ID #:
GEAC #:	□ GEAC Scanned	□ Look up GEAC

Please check "yes" or "no" for each question		**Yes**	**No**	**Notes**
1.	Are you sick today?	○	○	
2.	Do you have any allergies to medications (ex: gentamicin, hydrocortisone, neomycin, kanamycin), food, a vaccine component (ex: polysorbate) or latex?	○	○	
3.	Have you ever had a serious reaction after receiving a vaccine?	○	○	
4.	Have you ever had Guillain-Barré Syndrome (GBS)?	○	○	
5.	Have you had an organ transplant and are taking medication that affects your immune system?	○	○	
6.	Have you ever felt dizzy or faint before, during, or after a shot?	○	○	
7.	Are you anxious about getting a shot today?	○	○	

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.

Signature (Patient or Parent/Legal Guardian): _____Date:_____

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

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 or Technician, overseeing Pharmacist to sign and print name: _____

If using PREP Act, Ordering Pharmacist name and signature: _____

Ordering Pharmacist NPI:_____ Ordering Pharmacist License #: _____

If using Immunization Protocol, Ordering Physician name:_____

☑	**Age (yrs)**	**Influenza 24-25 Vaccine (Mfgr)**	**Dose**	**NDC**
	3+	**Fluarix** TIV PFS (GSK)	0.5 mL	58160-0884-52
	3+	**Flucelvax** TIV PFS (Seqirus)	0.5 mL	70461-0654-03
	3+	**Flulaval** TIV PFS (GSK)	0.5 mL	19515-0810-52
	3+	**Fluzone** TIV PFS (Sanofi)	0.5 mL	49281-0424-50
	18+	**Flublok** TIV PFS (PSC)	0.5 mL	49281-0724-10
	65+/SOT	**Fluad** TIV PFS (Seqirus)	0.5 mL	70461-0024-03
	65+/SOT	**Fluzone HD** TIV PFS (Sanofi)	0.5 mL	49281-0124-65
Sig: Administer 1 shot intramuscularly into the:			□ Left Deltoid	□ Right Deltoid

Additional
Lot Number:
Expiration Date:
VIS Date:
Clinic:
No Refills

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