giant eagle pharmacy

Immunization Administration Record

Influenza (Inactivated) Vaccine

Giant Eagle Advantage Card: | 4 | | | | | | | | | | | | □ Look up GEAC □ Applied

First Name		Last Name:		□M □ F
Address:		City:	State:	Zip:
Phone:	Date of Birth:	Age:	(YRS) Weight:	(LBS)
Insurance:	Group#:	ID#:		
Insurance:	Group#:	ID#:		
Primary Care Physician (PCP) First Name:		PCP Last Name:		
PCP Address:		City, State:		
PCP Phone:		PCP Fax:		

Precautions and Contraindications: *Please check "yes" or "no" for each question.*		**Yes**	**No**	**Notes**
1.	In the past month, have you been in contact with someone who has confirmed or suspected Coronavirus/COVID-19?			
2.	Over the last 14 days, have you had any of the following symptoms: cough, fever, loss of smell or taste, shortness of breath or chills?			
3.	Are you sick today?			
4.	Do you have allergies to food (EX: EGGS), medications, a vaccine component, or latex?			
5.	Have you ever had a serious reaction after receiving a vaccination?			
6.	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 that the payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made on my behalf to Giant Eagle Pharmacy for any services furnished to me by Giant Eagle Pharmacy. I authorize the release of any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents, any information necessary to determine these benefits or benefits payable for related services.

All Patients:
I authorize Giant Eagle to release my immunization records to Federal and state immunization registries, my physician, and health insurance provider.
I have received the Vaccine Information Sheet (VIS) associated with the vaccine described above. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Giant Eagle, Inc. and its 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, my receipt of this or these immunization(s). Giant Eagle, Inc. and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administrator of the vaccines described above.

For a school-sponsored immunization event (check the box to acknowledge, read the additional language, and initial below):
□ In addition to the above, I acknowledge the following:
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 legal guardian, receiving the applicable immunization without me being present on the clinic date of : _____. Initials:_____

Initial: _____ Medicare is my primary medical coverage, or I will be responsible for payment.
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 Legal Guardian): _____Date:_____

Print Name: _____

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.

Signature (Immunizer): _____Date:_____

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

If Pharmacy Intern, print name of overseeing Pharmacist: _____

□ Fluad QIV PFS (Seqirus) 0.5 mL	**□ Flublok QIV PFS (Protein Sciences) 0.5 mL**	**Lot Number:**
□ Fluarix QIV PFS (GSK) 0.5 mL	**□ Fluzone QIV MDV (Sanofi Pasteur) 0.5 mL**	**Expiration Date:**
□ 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**	**□ Protocol MD:**
Sig: Administer 1 shot intramuscularly into the:	**□ Left Deltoid □ Right Deltoid**	**No Refills**