Please answer yes or no to the questions below. If any questions are unclear, please ask for help.

Question	Yes	No
1. Are you sick today? What is your Temperature_____?	☐	☐
2. Do you have allergies to medications, food, vaccine component, or latex? If yes, please list:_____	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine, including fainting or feeling dizzy?	☐	☐
4. Do you have a long-term health problems such as heart disease, lung disease, asthma, diabetes, anemia, or other blood disorder?	☐	☐
5. Do you have cancer, HIV/AIDS, or any other immune system problem?	☐	☐
6. In the past 3 months, have you taken medications that affect your immune system such as prednisone, other steroids, anticancer drugs, drugs for rheumatoid arthritis, Crohn's, or psoriasis; or have you had radiation treatments?	☐	☐
7. Have you ever had a seizure disorder, brain disorder, Guillain-Barre syndrome (a condition that causes paralysis) or other nervous system problem?	☐	☐
8. Have you received any vaccinations in the past 4 weeks?	☐	☐
9. For Women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐

Note: The pharmacist will review these questions with you before giving the immunization. Based on your answers, they may refer you to speak with your physician to make sure the vaccine is right for you

Patient Name: _____ **Date of Birth**: ___/____/____

Address: _____ Phone: _____-_____

City: _____ State: _____ Zip: _____

Primary Care Physician:_____

Vaccine/Dose:

[ ] Afluria Quadrivalent 0.5ml-Seqirus-Lot Number: _____Exp Date: ___/____/___

[ ] Fluzone High Dose Quad 0.7ml-Sanofi-Lot number: _____ Exp Date:___/___/___

Route: (circle one) IM in Left Deltoid IM in Right Deltoid

Date of Administration and of VIS given to patient: _____/_____/2020

(Published Date VIS: 08/15/2019)

I understand and acknowledge the administration of this vaccine with be entered into the ShowMeVax system administered by the Missouri Department of Health and Senior Services unless I indicated otherwise below:

[ ] Do NOT report my vaccine information to ShowMeVax

___/___/2020 Patient Consent: X _____

Administered by: [ ] Pharmacist Dan Winkelmann, RPh

[ ] Pharmacist Haley Mann, PharmD

[ ] Other _____

___/___/2020 Signature*: _____

*By signing as administrator you are confirming that contraindications and side effects have been reviewed and current VIS was provided to the patient receiving vaccine.

ShowMeVax Notified: _____ date: ___/___/___ Protocol MD: Dr. Derek Morrison