Screening Checklist
for the Influenza Vaccination

The **Know You By Name** Pharmacy.™

Patient name: _________________________________ Phone: ___________________
Address: ________________________________ City: ____________ State: ___ Zip:__________
Insurance: ____________________ Member ID:____________________
Date of birth ___/____/_______ (must be 9 years of age or older)

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask us to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	▢	▢	▢
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	▢	▢	▢
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	▢	▢	▢
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	▢	▢	▢

I hereby claim that the above information is true and correct to the best of my knowledge. I consent that pharmacists affiliated with Gatti Pharmacy may administer this vaccine. I have been informed of the risks and benefits of the vaccine via the CDC-issued Vaccine Information Statement (VIS). I give permission to Gatti Pharmacy to seek compensation through my insurance, if applicable, knowing that my insurance may not fully cover the associated costs of the vaccine and administration. If this occurs, I understand that I am fully responsible for all costs associated with the administration of the vaccine. I also give consent to have this vaccine information shared as necessary with appropriate parties, including my healthcare provider and the immunization registry, Pennsylvania Statewide Immunization Information System (PA-SIIS).

Signature ____ date ___/____/______
Reviewed by ____ date ___/____/______

Consent for vaccination of individuals under the age of 18

As parent or legal guardian, I authorize the vaccination of ________________________ (child's name) with the inactivated influenza vaccine (IIV).

Parent or Legal Guardian's Signature _________________________________ date ___/____/______

Updated 7/19/2017