I want to receive:

☐ **High Dose (age 65+)** ☐ **Regular Flu Vaccine** ☐ **FluMist Nasal** (ages 3-49, if available)

Name: _____ Date of Birth_____ Age: _____

Street: _____ City_____ Zip _____

Phone: _____ Male/Female

OVER 65 ---- Last 4 of SSN:_____ Medicare ID: _____

UNDER 65 ---- RX BIN: _____RX PCN: _____Insurance ID: _____RX Group: _____

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider.	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Have you had any of the following symptoms in the past 14 days: Cough, muscle pain, fever (temp > 100.4F), unexpected shortness of breath, chills, or sore throat?	☐	☐	☐
3. Have you been in contact with anyone with confirmed or suspected Coronavirus (COVID-19) infection within the past 14 days?	☐	☐	☐
4. In previous years, have you received the influenza vaccine?	☐	☐	☐
5. Do you have allergies to medications, foods or any vaccine? (i.e. gelatin, eggs, latex, etc.)	☐	☐	☐
6. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
7. Have you, a sibling, or parent had a seizure or a brain or other nervous system problem? (i.e. Guillain-Barre Syndrome, encephalopathy)	☐	☐	☐
8. For women: Are you pregnant or is there a chance you could become pregnant in the next month?	☐	☐	☐

I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hy-Vee, its officers, employees and agents from any and all liability that might arise from this vaccination on behalf of myself, my heirs and personal representatives.

_____ _____

Signature **Date**

*****FOR OFFICE USE*****

_____ _____ _____

Given by **Admin Date** **Left/Right/Nasal**

Fluarix

HIGHDOSE 65+

FluMist Nasal

VIS Date: 8/6/21