SHARP Rees-Stealy Medical Centers

ADULT (18 years and older) INFLUENZA VACCINE ADMINISTRATION FORM 2020-2021

Patients Name: _____

Date of Birth: _____

Primary Physician: _____

MRN or Employee/Physician #:__ _____

(Or place patients label here)

FOR PATIENTS:

Please answer following questions:

1. Have you received the flu vaccine in the last 6 months? ☐ YES ☐ NO ☐ NOT SURE
2. Have you been ill in the last 24 hours? ☐ YES ☐ NO
3. Are you allergic to Neomycin/Gentamicin? ☐ YES ☐ NO
4. Do you have a history of Guillian Barre? ☐ YES ☐ NO
5. Have you ever had a previous influenza vaccine reaction? ☐ YES ☐ NO

_____ _____

Patient Signature Date

For Employees: I give consent to have this documented in my SRS medical record. ☐ YES ☐ NO

FOR CLINICAL STAFF ONLY:

Refer to standing order and influenza formulation grid

Influenza vaccine 0.5 ml. IM Site given: ☐ Right Deltoid ☐ Left Deltoid

Lot #: _____ Manufacturer: _____ Expiration date: _____

2 patient identifiers verified_____ Patient's temperature (if indicated): _____

No signs of adverse reaction noted ☐

_____ _____

Clinical Staff's Signature & Title Date

_____ _____

Ordering Physician's Signature (if required) Date

MD Verified Medication ☐

CDC Vaccine Information Sheet Given:

English ☐ Spanish ☐ Other ☐ Date: _____

CPT CODE	ADMIN CODES	CHECK ONE
90686X Fluarix 6 mos+	G0008	
90674C Flucelvax Cell Cultured Derived 4+ yrs	G0008	
90686V Flulaval 6 mos +	G0008	
90686Z Fluzone 6 mos+	G0008	
90694D Fluad 65yrs +	G0008	

Staff Use Only: Immunization history entered in EHR ☐ **Charges entered in EHR** ☐

SHARP Rees-Stealy Medical Centers

PEDIATRIC (6 months to 17 years old) INFLUENZA VACCINE ADMINISTRATION FORM 2020-2021

Patients Name: _____
Date of Birth: _____
Primary Physician: _____
Medical Record #: _____

(Or place patients label here)

FOR PATIENTS OR PARENTS

Please answer following questions:

1. Have you received the flu vaccine before? ☐ YES ☐ NO ☐ NOT SURE
2. Have you been ill in the last 24 hours with temperature greater than 100.6? ☐ YES ☐ NO ☐ NOT SURE
3. Are you allergic to Neomycin/Gentamicin? ☐ YES ☐ NO
4. Do you have a history of Guillian Barre? ☐ YES ☐ NO
5. Have you ever had a previous influenza vaccine reaction? ☐ YES ☐ NO

_____ Date _____

Patient or Parent/Guardian's Signature

FOR CLINICAL STAFF ONLY: Refer to standing order and influenza formulation grid

If patient/parent answers "Not sure" to question #1 and is younger than 9 years old administer dose and then send patient to pediatrics to review EHR for previous vaccination and schedule second dose after 30days if needed.

□ **6 months to < 9 years**

Influenza vaccine 0.5 ml. (Fluzone/Flulaval/Fluarix) Pediatric) IM, (repeat vaccine in 1 month if first year of receiving vaccine)

Site given: □ Right deltoid □ Left deltoid

Site given: □ Right thigh □ Left thigh

□ **4 years to < 9 years**

Influenza vaccine 0.5 ml IM (Flucelvax), (repeat vaccine in 1 month if first year of receiving vaccine)

Site given: □ Right deltoid □ Left deltoid

□ **9 years to 17 years** Site given: □ Right deltoid □ Left deltoid

Lot #: _____ Manufacturer: _____ Expiration date: _____

2 Patient identifiers verified □ Patient's temperature (if indicated): _____ No Reaction to Procedure □

_____ _____

Clinical Staff & Title Date

_____ _____

Ordering Physician's Signature Date

MD Verified Medication □

CDC Vaccine Information Sheet Given:

English □ Spanish □ Other □ Date: _____

CPT CODE	ADMIN CODES	CHECK ONE
90686X Fluarix 6 mos+	G0008	
90674C Flucelvax Cell Cultured Derived 4+ yrs	G0008	
90686V Flulaval 6 mos +	G0008	
90686Z Fluzone 6 mos+	G0008	

Staff Use Only: Immunization history entered in EHR ☐ **Charges entered in EHR ☐**

SHARP Rees-Stealy Medical Centers

VACUNA CONTRA LA GRIPE PARA ADULTO/NIÑOS FORMULARIO DE ADMINISTRACIÓN
ADULT/PEDIATRIC INFLUENZA VACCINE ADMINISTRATION FORM 2020-2021

Nombre del Paciente/Patient's name: _____

Fecha de nacimiento/Date of Birth:_____

Médico de atención primaria/Primary physician: _____

Número de expediente médico/Medical record #: _____

(Or place patients label here)

PARA PACIENTES O PADRES/ FOR PATIENTS OR PARENT

Por favor conteste las siguientes preguntas/ Please answer following questions:

Vacuna contra la gripe/ Influenza Vaccine

1. ¿Ha recibido la vacuna contra la gripe en los últimos 6 meses? /Have you received the flu vaccine in the last 6 months? ☐ Si ☐ No ☐ Not Sure
2. ¿Ha estado enfermo en las últimas 24 horas? / Have you been ill in the last 24 hours with temperature greater than 100.6? ☐ Si ☐ No ☐ Not Sure
3. ¿Es alérgico a Neomycin/Gentamicin?/ Are you allergic to Neomycin/Gentamicin? ☐ Si ☐ No
4. ¿Tiene usted historia de Guillian Barre?/ Do you have a history of Guillian Barre? ☐ Si ☐ No
5. ¿ Reacciones potencialmente letales a vacunas contra la influenza en el pasado? ☐ Si ☐ No

Paciente o Padres/Tutores Firma/
Patient or Parent/Guardian's Signature _____ Fecha/Date _____

FOR CLINICAL STAFF ONLY:

Refer to standing order and influenza formulation grid

Influenza vaccine 0.5 ml. IM Site given: ☐ Right Deltoid ☐ Left Deltoid

Lot #: _____ Manufacturer: _____ Expiration date: _____

2 patient identifiers verified_____ Patient's temperature (if indicated): _____

No signs of adverse reaction noted ☐

_____ _____
Clinical Staff's Signature & Title Date

_____ _____
Ordering Physician's Signature (if required) Date

MD Verified Medication ☐

CDC Vaccine Information Sheet Given:

English ☐ Spanish ☐ Other ☐ Date: _____

CPT CODE	ADMIN CODES	CHECK ONE
90686X Fluarix 6 mos+	G0008	
90674C Flucelvax Cell Cultured Derived 4+ yrs	G0008	
90686V Flulaval 6 mos +	G0008	
90686Z Fluzone 6 mos+	G0008	
90694D Fluad 65yrs +	G0008	

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PATIENT LABEL

Children (follow up)

6 months to less than 9 years of age that meet the criteria should receive two doses of a 2020-2021 seasonal influenza vaccine during the 2020-2021 influenza season.

Criteria:

- The Childs vaccination status is unknown
- The Child did not receive influenza vaccine in 2020-2021
- The Child never received a second dose at all before they were 9 years old

Second dose is due 30 days or more after the 1st.

Your Child is due after: _____

Contact your Pediatric doctor to schedule the nurse visit only appointment for the 2nd dose. Or book an appointment on Follow My Health.

THANK YOU!

SHARP Rees-Stealy Medical Centers

FLU MIST ADMINISTRATION FORM 2020-2021

Patients Name: _____

Health Plan: _____

Primary Physician: _____

Medical Record #: _____

(Or place patients label here)

FOR PATIENTS OR PARENTS

Please answer following questions:

The following questions will help determine if the person is an appropriate candidate for FluMist

1. Have you received the flu vaccine before? ☐ YES ☐ NO ☐ NOT SURE

2. Do any of the following apply to the person being vaccinated with FluMist? ☐ YES ☐ NO

(If your answer is YES, the person to be vaccinated cannot receive FluMist.)

- Has been ill in the last 24 hours with temperature greater than 100.6
- Allergy gentamicin, gelatin, or arginine
- Life-threatening reactions to influenza vaccine in the past
- Is between 2 years and 17 years, and currently receiving aspirin or aspirin-containing therapy
- Is under 2 years of age

3. Do any of the following apply to the person being vaccinated? ☐ YES ☐ NO

(If your answer is YES, please determine whether the person to be vaccinated can receive FluMist.)

- Has asthma?
- Has your healthcare provider told you in the past 12 months that your child (2 yrs to 5 yrs) has wheezing or asthma?
- Experienced Guillain-Barré syndrome within 6 weeks following any prior influenza vaccination?
- Has long-term health problems with weakened immune system or heart, lung, liver, kidney, or metabolic disease (e.g., diabetes), or blood disorders?
- Is pregnant or nursing?

4. Does the person to be vaccinated expect to have close contact within the next 7 days with a person whose immune system is so severely compromised to the degree that he/she must be in a protective environment, such as a negative-pressure hospital room?

☐ YES ☐ NO

(If your answer is YES, the person to be vaccinated cannot receive FluMist.)

_____ _____

Patient or Parent/Guardian's Signature Date

CPT CODE	ADMIN CODES	MD/APP Signature	Clinical staff signature & title
90672M Flumist Nasal 2yrs-17yrs	**90473**		

MD Verified Medication ☐

Staff Use Only: Immunization history entered in EHR ☐ **Charges entered in EHR** ☐

SHARP Rees-Stealy Medical Centers

GRIPE NIEBLA ADMINISTRACIÓN FORMA 2020-2021

Nombre de los pacientes: _____
Nombre de seguro médico: _____

Médico primario: _____

Registro médico: _____

(O coloque la etiqueta de pacientes aquí)

PARA PACIENTES O PADRES

Por favor, conteste las siguientes preguntas:

Las siguientes preguntas ayudarán a determinar si la persona es candidato para FluMist

1. ¿Ha recibido la vacuna contra la gripe en los últimos? /Have you received the flu vaccine before? ☐ Si ☐ No

2. Alguno de los siguientes términos aplican a la persona que será vacunada con FluMist? ☐ Si ☐ No

(Si su respuesta es afirmativa: la persona que pide la vacuna, no puede recibir FluMist).

- ¿Ha estado enfermo en las últimas 24 horas? / Have you been ill in the last 24 hours with temperature greater than 100.6?
- Alergia a gentamicina, gelatina o arginina
- Reacciones potencialmente letales a vacunas contra la influenza en el pasado
- Tiene entre 2 y 17 años de edad y actualmente recibe aspirina o terapia que contenga aspirina
- Es menor de 2 años de edad

3. ¿Alguno de los siguientes términos aplican a la persona que será vacunada? ☐ Si ☐ No

(Si su respuesta es Sí, favor de determinar si la persona que pide la vacuna puede recibir FluMist.)

- ¿Tiene asma?
- ¿Ha sido informado por su médico primario si su hijo (2 a 5 años) tiene sibilancias o asma en los últimos 12 meses?
- ¿Ha experimentado el síndrome de Guillain-Barré dentro de 6 semanas después de una vacunación de gripe en el pasado?
- ¿Tiene problemas de salud crónicos con el sistema inmune, corazón, pulmones, hígado, riñones o enfermedad metabólica (ej. diabetes), o enfermedades de la sangre?
- ¿Está embarazada o amamantando?

4. La persona que pide la vacuna espera tener contacto cercano dentro de los próximos 7 días con una persona cuyo sistema inmune está severamente comprometido al grado que él/ella debe estar en un entorno protector, como una sala de hospital de presión negativa? ☐ Si ☐ No

(Si su respuesta es afirmativa, la persona que pide la vacuna no puede recibir FluMist).

_____ _____

Paciente o firma del padre/tutor Fecha

CPT CODE	ADMIN CODES	MD/APP Signature	Clinical staff signature & title
90672M Flumist Nasal 2yrs-17yrs	**90473**		

MD Verified Medication ☐

Staff Use Only: Immunization history entered in EHR ☐ **Charges entered in EHR** ☐