☐ Cy's ☐ Sinclair ☐ Tile ☐ Wanakah ☐ Kenmore ☐ Family Medical ☐ Larwood Pharmacy

Adult Influenza Vaccine Consent Form

(Patients 19 years and older)

Last Name: _____ First Name: _____ M.I.:_____

Date of Birth:___ / ___/___ Age: _____ Circle: Male / Female

Address:_____ Phone Number: (_____)_____-_____

City _____State: _____Zip: _____

Insurance Company: _____

ID#: _____ RXBIN:_____ RXGroup: _____ Person #: _____

Primary Care Physician to notify of this immunization: _____

Location/Phone # (if known): _____

CHECK ONE:

YES	NO	
☐	☐	**Have you tolerated an influenza vaccine previously?**
☐	☐	**Have you had a severe reaction to an influenza vaccine previously?**
☐	☐	**Do you have a severe allergy to eggs?**
☐	☐	**Do you have allergies to any vaccine/vaccine component (e.g.: thimerosol)?**
☐	☐	**Do you feel sick today?**
☐	☐	**Do you have a fever today?**
☐	☐	**Do you have a bleeding disorder or take blood thinners?**
☐	☐	**Are you pregnant?**
☐	☐	**Have you ever had Guillain-Barre syndrome?**

By signing below, I attest that I have received a copy of the Vaccine Information Statement for the Influenza Vaccine dated _____ . I have had a chance to read and ask questions about this vaccine and am satisfied with the responses. I understand the benefits and risks associated with receiving a vaccination. I understand that this vaccination is highly effective but does not guarantee immunity against any or all strains of the flu. I request that this vaccine be administered to me. I understand that it is recommended to remain in the facility for 15 minutes after the vaccination. I accept responsibility for seeking appropriate medical care for any medical problems associated with receiving this vaccine. I release the pharmacy and its employees from any responsibility or liability with regard to administration of the influenza vaccination. I have had the opportunity to receive and understand the pharmacy's privacy policy with regard to health care information. I authorize the release of my personal and health care information strictly for the purpose of billing this vaccine and its administration. I authorize payment of insurance benefits for services provided to me by the pharmacy, and for the pharmacy to receive payment for such services provided to me. I understand that I will be responsible for any payment, in full, if my insurance company fails to cover this vaccine and its administration for any reason. I authorize the pharmacy to notify my primary health care provider of the receipt of this vaccination.

Signature of Recipient _____ **Date**_____

Vaccination name: _____

Manufacturer: _____Lot: _____ Site: LD / RD

Administered by: _____Date:___ /___/ ___ Time:____ : ____ AM/PM

Title: _____ Signature: _____