

COPAY \$ \_\_\_\_\_  
 COPAY PAID: Y / N  
 BUSINESS/PATIENT



STORE#: \_\_\_\_\_

## Influenza Vaccine Consent & Release Form

**PATIENT INFORMATION (PLEASE PRINT)** *If you are Pregnant, Immunocompromised, or 65 years and older, please notify the pharmacist.*

Last Name:		Date of Birth:	

**PHYSICIAN (M.D.) INFORMATION** *Please provide your Primary Care Physician's information if available.*

M.D. Name: (last name, first name)		
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**INSURANCE INFORMATION** *Please provide all current insurance information for processing your claim.*

<b>REQUIRED FOR 65 AND OLDER</b>	
Please provide last 4 digits of SS# _ _ _ _	

The following questions will help us determine if you are eligible to receive the Inactivated Influenza Vaccine today.				
Please answer each question by checking a box.		YES	NO	DON'T KNOW
1.	Have you received a Flu shot in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have a fever or are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have a history of Guillain-Barre syndrome? (severe temporary muscle weakness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I consent to receiving the following vaccine from Times Pharmacy. I understand that I am giving Times permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company, as applicable, to enable Times to process my insurance claims with respect to the vaccination. I understand that if my insurance does not pay for the services rendered on this form, I am responsible for payment. I, for myself, my heirs, executors and assigns hereby release Times and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with this vaccination. I also acknowledge that I received a copy of the Vaccine Information Statement (VIS) for the vaccine stated below and that I understand the benefits and risks associated with the described vaccine.

\_\_\_\_\_  
**Patient Signature** \_\_\_\_\_  
**Date**

**FLU VACCINE INFORMATION** to be completed by Pharmacist VIS: \_\_\_\_\_

Affix vaccine information sticker HERE	SITE OF INJECTION : <u>IM</u> - <u>Left arm / Right arm (circle)</u>	
	_____	_____
	<b>Pharmacist Signature</b>	<b>Date</b>