Brookshire Brothers PHARMACY

INFLUENZA VACCINE CONSENT FORM

I request that the INFLUENZA vaccine to be administered to me or the person named below whom I am authorized to make this decision for. I agree to remain at the clinic for at least 10 minutes after receiving my vaccination. I have read or have had information about this vaccine explained to me. I understand the benefits and risks associated with the vaccine and choose to assume the risk. As with all medical treatment, I realize that there is no guarantee that I will not experience an adverse side effect from the vaccine. Furthermore, I hereby release and discharge Brookshire Brothers, Inc., its affiliates and officers, board members, and employees from any and all liability for illness, injury, loss or damage which may result from this immunization. I will communicate the information given today to my primary care physician if I have one.

****For Medicare Part B card holders:** PLEASE PRINT YOUR NAME AND MEDICARE NUMBER **EXACTLY** AS IT APPEARS ON YOUR CARD.

(*Please Print*) First Name_____Middle Initial____Last Name_____

Medicare Part B Card ID#_____(*including the letter at end of number)*

Street Address:_____

City:_____State:_____Zip Code:_____Phone:_____Date of Birth:_____

Sex:_____Primary Care Physician (*First and Last Name):*_____

Physician Address:_____City:_____

Physician Telephone Number:_____Allergies, Chronic Disease:_____

Screening Questionnaire for Adult Immunization

The following questions will help us determine which vaccines may be given to you today. Please circle the answer. If you do not understand the question, please ask the pharmacist to explain it to you.

1.Do you have a fever or any type of infection today?	Yes No
2.Do you have any allergies to medications, gelatin, eggs, any vaccine or vaccine component (such as thimerosal)?	Yes No
3.Have you ever had a serious reaction after receiving a vaccination?	Yes No
4.Do you, or any person you live with or take care of have Guillian-Barre Syndrome, cancer, leukemia, AIDS, or any other immune system problem?	Yes No
5.Do you, or any person you live with or take care of, take steroids (including Prednisone &/or Cortisone), or anticancer drugs?	Yes No
6.During the last year have you received a blood transfusion, been given blood plasma, or been given an immune globulin?	Yes No
7.For Women: Are you pregnant or is it possible that you may become pregnant in the next 3 months?	Yes No
8.Have you ever received an influenza vaccination?	Yes No
9.Have you received any vaccinations in the past 4 Weeks (28 days)?	Yes No

*Note to Medicare Part B Patients: ☐ *I authorize Brookshire Brothers and Allwin to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Allwin as my Medicare Part B provider.*

PATIENT SIGNATURE:_____DATE:_____

----------PHARMACY USE ONLY----------

Immunizer & Title_____ Store#:_____ Date of VIS: 8/7/2015

Drug Name:_____Mfr: _____Lot #:_____ Exp Date:_____

Amount Administered: _____ Injection Site: *(circle one)* R or L deltoid

Today's Date:____/____/_____ RPh Signature: _____

RPh must enter vaccination information (within 24 hours) into the LINKS system for ALL immunizations (not just minors).