Brookshire Brothers
PHARMACY

VACCINE ADMINISTRATION CONSENT FORM

I request that the ______________________________ vaccine 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 Dr. James Rick Martin and 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.

INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE:

DATE OF VACCINATION____/_____/_______ TELEPHONE # ________________________________
NAME____ DATE OF BIRTH_______________________________
ADDRESS____ CITY____________ ST______ ZIP CODE________
DOCTOR NAME____ MEDICARE B #______________________________
DOCTOR ADDRESS____ DR. PHONE_______________
ALLERGIES____ MEDICAL CONDITIONS________________________

QUESTIONS ABOUT THE PERSON RECEIVING THE VACCINE:			
Yes	*No*	*Don't Know*	*These questions help determine your eligibility for certain vaccines.*
			Are you sick today?
			Do you have allergies to eggs, gelatin, latex, yeast, food, medications, vaccines, or vaccine components?
			Have you ever had a serious reaction after receiving a vaccine?
			Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?
			Do you, or anyone you're in close contact with, have cancer, leukemia, HIV/AIDS, or any other immune system problem?
			In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?
			Have you had a seizure, brain, or other nervous system problem?
			During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?
			For women: Are you pregnant, or is there a chance you could become pregnant within the next 3 months?
			Have you ever received this vaccination?
			Have you received any vaccine within the past 4 weeks?

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.*

SIGNATURE____**DATE**___________________________

--PHARMACY USE ONLY--

IMMUNIZER & TITLE__________________________________ STORE #____________ TODAY'S DATE____________________

VACCINE NAME_____________________________ MFR_____________ LOT #_________________ EXP DATE_____________

AMOUNT ADMINISTERED_______ML INJECTION SITE *(CIRCLE ONE)* R DELTOID/L DELTOID/R ARM/L ARM UNDER 18: Y*/N *(CIRCLE ONE)*

IMMUNIZER SIGNATURE_______________________________________ DATE OF VIS______________

BILLING INFO: ☐ CASH ☐ 3RD PARTY ☐ 3RD PARTY ON FILE 3RD PARTY NAME________________ BIN____________ PCN_______

3RD PARTY ID#______________________ GROUP_______________ PERSON CODE________

Fax (within 24 hrs) to Dr. Martin at (936) 634-1406 or (866) 482-4043 and to the patient's primary care physician as listed above within 14 days.
*If patient is a minor (under 18), fax completed form and Immtrac Consent form to Rebekah Modisette at (281) 432-8201.