



Address 592 West Pine Street
 City, State Zip Bethel OH 45906

Telephone 734 6242

Vaccine Consent and Administration Record Pharmacist Immunization Program

For clinic use:
 Shot # _____

Information about patient receiving vaccination (Please print):

Last Name _____ First Name _____ Middle Init. _____ Date of Birth _____ Sex _____
 Street _____ City _____ State _____ Zip _____ Phone # _____ M / F _____

Medical Condition(s) _____ Allergies _____

Primary Care Physician (PCP) _____ PCP Contact Information _____

Please answer the following questions:

- | | YES | NO | DON'T KNOW |
|--|--------------------------|--------------------------|--------------------------|
| 1. Are you sick today? (For example: a cold, fever or acute illness) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies or reactions to medications, foods or any vaccine? (For example: eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please list _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, AIDS or any other immune system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure, brain, or other nervous system problem? (For example: Guillain-Barré syndrome) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or nursing? Could you become pregnant during the next month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please read the following statements and sign on the signature line below

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I voluntarily authorize and direct my health care provider at CVS/pharmacy to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at CVS/pharmacy (standing order for purposes of treatment, payment or other health care operations (such as administration or quality assurance). This authorization permits CVS/pharmacy to disclose the following medical records: only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

I acknowledge that I have received the CVS/pharmacy Notice of Privacy Practices, which is provided on the back of the Patient copy of this consent form. Medicare Billing: I do hereby authorize CVS/pharmacy 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.

X Signature of patient to receive vaccine or person authorized to make the request (parent/guardian) _____ Date: _____

This section to be completed by Pharmacy:

VACCINE ADMINISTRATION INFORMATION:

Date Fluzone Product Serif Manufacturer OS Vol (mL) 0.5 Route IM Site del
 Lot # VH454AD Exp. Date 6-12 VIS Version Date 7-11 Date VIS Given to PT _____ Administering Immunizer Name & Title _____

PATIENT INSURANCE INFORMATION:

Primary: Plan Name: _____ BIN# / Condor: _____ ID #: _____ Group: _____
 Secondary (if applicable): Plan Name: _____ BIN# / Condor: _____ ID #: _____ Group: _____

Affix Rx Label Here