2020-2021 Flu Consent

Name: _____

Address: _____

_____

Phone: _____ Date of Birth: _____

Physician: _____

A record of this immunization will be released to your physician as required by state law.

(For Pharmacy Use Only)
Affix Prescription Label Here

Vaccine Name (circle):

Fluarix/Afluria/Fluad/Flulaval/Fluzone/Fluzone HD

Lot #: _____ Exp. Date: _____

Arm Administered: LEFT / RIGHT

Current VIS Date Given to Patient: 08/15/19

COVID-19 Check	**Y**	**N**	**(?)**
Do you have a fever or feel feverish?			
Do you have a cough?			
Do you have difficulty breathing?			
Do you have chills?			
Do you have muscle pain or body aches?			
Do you have any GI distress?			
Do you have any loss o\r altered taste/smell?			
Have you traveled in the past 14 days or been asked to self quarantine?			

FLU Vaccine Questionnaire:	**Y**	**N**	**(?)**
Are you sick today?			
Do you have any allergies to medications, food, vaccine components, or latex?			
Have you ever had a serious reaction to a vaccination?			
Have you ever had a seizure, brain or other nervous system injury?			

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid, or other third party payer as needed and request payment of authorized benefits be made on my behalf to Fruth Pharmacy, Inc.

- I confirm the information is accurate.
- I acknowledge that if my insurance does not cover the cost of administering the vaccine to the pharmacy, that payment must be made at the time of administration of the vaccine.
- I acknowledge that my vaccination records may be shared with federal, state, or local agencies for registry reporting.
- I acknowledge that patients should remain in the waiting area for 20 minutes post administration.
- I acknowledge receipt of Fruth Pharmacy's Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization/vaccine does not substitute for an annual check-up with primary care physician.
- I have read, or have had read to me the Vaccine Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Fruth Pharmacy, Inc., its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Signature: _____

Pharmacist: _____

Date: _____