LakeHills Pharmacy

FLU SHOT CONSENT AND RELEASE

512-608-9355 www.lakehillsrx.com

NAME (Last)	(First)	DATE OF BIRTH Month_____Day_____Year_____Age_____	
ADDRESS		GENDER MALE_____ FEMALE_____	
CITY	STATE	ZIP	PHONE#
Name of Primary Care Physician			

PLEASE PROVIDE BOTH PHARMACY AND MEDICAL INFORMATION OR COPIES OF THE ID CARDS AS THERE ARE MULTIPLE WAYS VACCINATIONS CAN BE BILLED

☐ Prescription Insurance Coverage
If you are not the cardholder, provide primary cardholder's name, birthdate and relationship:
_____
BIN_____PCN_____Group_____ID_____

☐ Medical Insurance Coverage
If you are not the cardholder, provide primary cardholder's name, birthdate and relationship:
_____
Plan ID_____ Member ID_____Group_____

☐ $20 Cash Payment Provided

Answer All For Vaccine Administration	**Please answer these questions by checking the boxes**	**YES**	**NO**	**Know Don't**
	1. Are you **sick** today?			
	2. Do you have a serious allergy to **ANY** medications or foods? (Example: **Eggs**, Gelatin, Thimerosal, Neomycin, Gentamicin). If YES Please list:_____			
	3. Have you ever had a serious reaction or fainted after receiving any vaccination?			
	4. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks of having a flu vaccine?			
	5. Do you have sensitivity to **latex**? (Example: gloves or bandages)			

ONLY RETURN THIS FORM IF YOU WANT THIS VACCINE

THIS ENTIRE FORM MUST BE FILLED OUT, COPIES OF YOUR INSURANCE CARDS OR $20 PAYMENT PROVIDED AND A PARENT/GUARDIAN SIGNATURE OR YOUR CHILD WILL NOT BE VACCINATED

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Lake Hills Pharmacy has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Lake Hills Pharmacy, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Lake Hills Pharmacy permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO or insurance company or immunization registry, as applicable, to enable Lake Hills Pharmacy to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Lake Hills Pharmacy and its affiliates, owners, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of the Lake Hills Pharmacy in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

_____ _____ _____

Parent/Guardian Signature Relationship to Child Date

----------**BELOW LINE FOR PHARMACY USE ONLY**----------

Vaccine	Lot#	Exp Date	Manufacturer	Dosage	Site of Injection	VIS Date
Seasonal Influenza			**FLUARIX Preservative Free**	**0.5ml**	**RD LD NASAL**	08/06/21

Signature of Pharmacist_____RPh Date Administered_____