IMMUNIZATION CONSENT FORM

LAST Name: _____
First Name: _____ **Middle Initial:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **DOB (m/d/y):** ____/____/_____ **Age:** _____ **Sex (M/F):** _____

Influenza Precautions and Contraindications: **Please check YES or NO for each question.**	**YES**	**NO**
1. Are you sick today?	□	□
2. Do you have sensitivity to latex?	□	□
3. Are you allergic to chicken eggs or egg products?	□	□
4. Are you allergic to Thimerosal (a preservative in some cleaning products or contact lens solution)?	□	□
5. Do you have any allergies to medications, food or vaccines? Allergies_____	□	□
6. Have you ever had a serious reaction after receiving an immunization?	□	□
7. Have you ever fainted or felt dizzy after receiving an immunization?	□	□
8. Are you currently taking cortisone, prednisone, other steroids, anti-cancer drugs, or had X-ray recently?	□	□
9. Are you currently being treated for Cancer, leukemia, AIDS, or any other immune system problem?	□	□
10. Are you currently being treated for a long term health problem? Health Issue_____	□	□
11. During the past year, have you received a transfusion of blood, blood products, or immune globulin?	□	□
12. Have you received any vaccines in the past 4 weeks? If Yes, which vaccines_____	□	□
13. Do you have a history of Guillain-Barré Syndrome or an active neurological disorder (ex. Seizures)?	□	□
14. Are you a parent, family member, or caregiver to a new born infant, or young children?	□	□
15. WOMEN: Are you, or do you suspect, you are pregnant or may become pregnant in the next 4 weeks?	□	□

CONTACT YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER BEFORE RECEIVING THIS VACCINE IF YOU CHECKED YES ON ANY OF THE ABOVE QUESTIONS.

HAVE YOU HAD THE FOLLOWING VACCINES		
Pneumococcal Vaccine – You may need two different pneumococcal shots*	□	□
Shingles Vaccine	□	□
Whooping Cough (Tdap) Vaccine	□	□

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small.

Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate, presumable allergic reactions such as hives, angioedema, allergic asthma, or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes, or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes, to a few hours, after the shot.

Which Vaccine(s) would you like to receive today?

□ Influenza **Over 65 Years Old** □ Influenza Normal □ Pneumococcal □ Tetanus (Td)

□ Whooping Cough (Tdap, DTaP) □ Respiratory Syncytial virus (RSV) □ Zoster (Shingles)

Name of Primary Care Physician (PCP): _____

City and State of Office Location: _____

Vaccine Information Sheet (VIS): **Publication Date:** _____

Patient Receipt Date: _____

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with the influenza and pneumococcal vaccines. A copy of the Vaccine Information Sheet has been provided to me. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release the Rock Hill Pharmacy and its employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). Rock Hill Pharmacy and the aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The Rock Hill Pharmacy will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES** to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices.

X _____ _____

Signature/Legal Guardian — Date

_____ _____

Print Name — Immunizer's Signature

Medicare Beneficiaries ONLY

I understand that I am giving Rock Hill Pharmacy permission to ask for Medicare payments for my medical care, including supplies and equipment.

I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.

I understand that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. I understand that a copy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or co-insurance amounts.

Therefore, I ask that payment of authorized Medicare benefits be made to either me or on my behalf to Rock Hill Pharmacy for any services or items furnished to me by Rock Hill Pharmacy. I authorized any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits for related services.

I have received a copy of the Medicare Supplier Standards.

X _____ _____

Signature of Beneficiary — Date

_____ _____

Print Name — HICN

PHARMACY USE ONLY

Place Rx Label Here:

Manufacture: _____ Site of Injection: R / L Deltoid IM / SQ

Expiration: _____ Lot: _____