OPERATOR OF THESE FINE ESTABLISHMENTS

MOYE'S PHARMACY | WENDER & ROBERTS PHARMACY EST. 1918 | SOUTHCARE Pharmacy | Falcon Wholesale

2017-2018 VACCINE CONSENT FORM

I have read or have had explained to me the Vaccine Information Statement about the vaccine listed below. I had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine being administered and authorize the administration of the vaccine to me or to the person named below for whom I am authorized to make this decision. I have also read or been offered a copy of the pharmacy's Notice of Privacy Practices.

Print Name:_____Birth Date:_____Gender: ☐ Male ☐ Female

Address:_____City/Zip:_____Phone #:_____

Primary Physician:_____Physicians Phone#:_____

Allergies:_____Medicare#:_____

Vaccine Requested:_____

PAYMENT INFORMATION (please check one):

☐ Medicare B ☐ Medicaid ☐ Cash/Check ☐ Prescription Insurance

We will need a copy of your Medicare B or Medicaid card, if enrolled, or any prescription insurance you wish to be billed for your flu shot. You will be charged the co-payment amount, if any, as determined by your insurance provider.

Circle One

1.Is the patient currently under the care of Hospice……YES NO

If YES, **STOP HERE**. Hospice must provide your flu shot or patient must pay for the vaccine.

2.Have you been given a flu shot somewhere else for this year (2017)?.....YES NO

If so, Medicare will not pay for another flu shot until after January 1, 2018.

3.Have you had a physical examination within the past year?.....YES NO

4.Are you sick today?.....YES NO

5.Do you have allergies to medications, eggs or other food, a vaccine component, or latex?.....YES NO

** If yes list allergies_____

_____

6.Have you ever had a serious reaction after receiving a vaccination?.....YES NO

7.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?.....YES NO

8.Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?.....YES NO

9.Have you had a seizure, brain disorder, Guillian-Barre Syndrome or other nerve problem?.....YES NO

10.**For women:** Are you pregnant or is there a chance you could become pregnant during the next month?..... YES NO

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I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient ('Ward'). I have received a copy of the applicable Vaccine Information Statement[s] and I have read the adverse reactions associated with the administration of vaccine[s]. Furthermore, I consent to the administration of the vaccine[s] requested above to me or my Ward and acknowledge that, as a condition to administration of the vaccine[s], myself or my Ward must remain under the observation of the administering pharmacist for a period of not less than 15 minutes. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about the immunization[s]. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization[s] or the receipt of the immunization[s] by the person named above for whom I am the Ward. My medical record may be shared with my primary care provider or other healthcare provider and the medical record of my Ward may be shared with his/her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release **Moye's Pharmacy**, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization[s]. Neither **Moye's Pharmacy** nor any of the Released Parties shall, 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 vaccine[s] described above. I authorize **Moye's Pharmacy** to (a) notify my or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (3) make any other disclosures required by law. **Moye's Pharmacy** will use and disclose your personal and health information or the personal and health information of your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

For Patients receiving Live Vaccines only: I further certify that I have read the list of contraindications to the vaccine[s] set forth above and neither me or my Ward have a contraindication to the vaccine[s] to be administered.

Signature of person to receive vaccine or person authorized to make the request (parent or guardian). If we are billing your insurance, you authorize the release of any medical/other information necessary to process the claim and request payment to our pharmacy. **If your insurance denies payment, you will be charged $30.00 per vaccine**. Your pharmacy will retain this record in its medical files.

_____ _____

SIGNATURE/LEGAL GUARDIAN DATE OF VACCINATION/DATE VIS GIVEN

_____

PRINT

FOR CLINICAL/OFFICE USE: Select Location- ☐ Stockbridge ☐ McDonough Central ☐ McDonough North ☐ Hampton ☐ Locust Grove ☐ Wender WPF ☐ Wender Roswell ☐ Wender Dallas ☐ Southcare ☐ Trenton ☐ Off-Site: _____

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ADMINISTRATIVE RECORD (For Pharmacy Use ONLY)

VACCINE: Influenza	EXPIRATION DATE:	VACCINE:	EXPIRATION DATE:	VACCINE:	EXPIRATION DATE:
VIS VERSION 2017-2018	SITE OF INJECTION:	VIS VERSION:	SITE OF INJECTION:	VIS VERSION:	SITE OF INJECTION:
MANUFACTURER: Seqirus Inc.	DOSAGE:	MANUFACTURER:	DOSAGE:	MANUFACTURER:	DOSAGE:
LOT NUMBER:	ROUTE OF ADMIN: Injection	LOT NUMBER:	ROUTE OF ADMIN:	LOT NUMBER:	ROUTE OF ADMIN:
BRAND NAME: Flucelvax	DATE NEXT VACCINE DUE (IF APPLICABLE):	BRAND NAME:	DATE NEXT VACCINE DUE (IF APPLICABLE):	BRAND NAME:	DATE NEXT VACCINE DUE (IF APPLICABLE):
DATE ADMINISTERED:	DATE M.D. NOTIFIED	DATE ADMINISTERED:	DATE M.D. NOTIFIED	DATE ADMINISTERED:	DATE M.D. NOTIFIED
ENTERED INTO GRITS:	DATE	ENTERED INTO GRITS:	DATE	ENTERED INTO GRITS:	DATE

ADMINISTERING PHARMACIST INFORMATION

PHARMACIST NAME _____

PHARMACIST LICENSE NUMBER _____

R.N. NAME _____

R.N. LICENSE NUMBER _____

STORE ADDRESS: _____

STORE PHONE NUMBER _____

(place RX label here)

ADVERSE EVENTS/COMPLICATIONS & NOTES

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Report all adverse reactions to the Federal Vaccine Adverse Event Reporting System