NORTHERN PHARMACY & Medical Equipment
We have been here for over 80 years, there must be a reason!

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Influenza Vaccine Consent Form

(Inactivated – Injectable) 2025-2026
Must be 9 years of age or older
Must remain in the pharmacy for 15 minutes after the injection

☐ Patient has been checked in Immunet

SECTION A Please print clearly.

Last Name:		**First Name:**		
Address:				
Address 2:	**City:**	**County:**	**State:**	**Zip:**
Email:		**Phone:**		
Mother's Full Maiden Name:				
Race:	▢ American Indian or Alaska Native	▢ Asian	▢ Native Hawaiian/Other Pacific Islander	
	▢ Black or African American	▢ White	▢ Other Race	
Ethnicity:	Hispanic?	☐ Yes	☐ No	

[Place RX Label Here]

Are you 19 years old or older? Ask a pharmacist if you need the **Hepatitis A and B, MMR, Tdap, HPV, Prevnar-13, Pneumovax, and Shingrix Vaccines**.

Language:	
DOB:	**Age:**
Gender:	▢ Female ▢ Male
Physician:	
Physician's Phone:	
SSN:	

SECTION B The following questions will help us determine your eligibility to be vaccinated today.

1.	Are you currently sick with a fever or any type of infection, including tuberculosis?	☐ Yes	☐ No
2.	Do you have a severe (life-threatening) allergy to **eggs**, or any component (or part) of this vaccine, including formaldehyde, sucrose, octylphenol ethoxylate, sodium phosphate, sodium chloride, beta-propiolactone, cetyltrimethylammonium bromide, polysorbate 80, sodium taurodeoxycholate, hemagglutinin, neuraminidase, squalene, sorbitan trioleate, sodium citrate dihydrate, citric acid monohydrate, neomycin, kanamycin, barium, hydrocortisone, sodium deoxycholate, ovalbumin, and alpha-tocopheryl hydrogen succinate?	☐ Yes	☐ No
3.	Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes	☐ No
4.	Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving a vaccine?	☐ Yes	☐ No

Please remain in the pharmacy for 15 minutes following the vaccination.
If you leave, you are doing so against medical advice

SECTION C

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. Further, I hereby give my consent to the healthcare provider of Northern Pharmacy and Medical Equipment to administer the vaccine I have requested above. I understand the vaccine is trivalent. **Egg based vaccines will protect against an A/Victoria/4897/2022 (H1N1)pdm09-like virus, an A/Croatia/10136RV/2023 (H3N2)-like virus; and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus and cell based vaccines will protect against an A/Wisconsin/67/2022 (H1N1)pdm09-like virus, an A/District of Columbia/27/2023 (H3N2)-like virus; and a B/Austria/1359417/2021 (B/Victoria lineage)-like virus.**. I understand the risks and benefits associated with the above vaccine and have received, read, and/or explained to me the Vaccine Information Statements on the vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless the applicable Provider, Northern Pharmacy and Medical Equipment's staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider

will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at Northern Pharmacy and Medical Equipment 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 Northern Pharmacy and Medical Equipment, my Primary Care Physician, my insurance and/or state or federal registries, where required, for treatment, payment or other healthcare operations.

I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my pharmacy benefits. **I understand that Northern Pharmacy and Medical Equipment is not set up to bill medical insurance for vaccination.**

_____	_____
Signature of Patient or Legal Guardian	Date
_____	_____
Patient's Full Name	DOB

----------FOR CLINIC/OFFICE USE ONLY----------

SECTION D Complete BEFORE vaccine administration	
1. I have reviewed the **Patient Information** and **Screening Questions**.	Initials: _____
2. I have verified that this is the vaccine requested by the patient.	Initials: _____
3. The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (**Perform 3-way NDC match**)	Initials: _____
4. I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below.	Initials: _____

SECTION E Complete AFTER vaccine administration			
Immunizer:			**Title:**
Date of Immunization:		**Site of Injection:** ☐ LA/IM ☐ RA/IM	
Vaccine/MFG/Dosage **QUAD** ☐ Afluria/Seqirus/0.5ml ☐ Fluarix **PF**/0.5ml ☐ Fluarix /0.5ml ☐ Flucelvax/Seqirus/0.5ml ☐ Fluzone/Sanofi/0.5ml **65 AND OLDER ONLY** ☐ Fluad/Seqirus/0.5ml ☐ Fluzone Quadrivalent **HD**/Sanofi/0.7ml		**Lot #:**	**Expiration Date:**
Insurance: ☐ Major Med	☐ Medicare ☐ Cash	☐ Rx Coverage ☐ Other _____	**VIS Date:**

Signature of immunizer who administered vaccine(s) and provided VIS to patient: _____