FOR OFFICE USE	COPAY: $_____	COPAY PAID: Y / N	TYPE: BUSINESS / PATIENT
STORE: #_____	APPT DATE & TIME: _____		

Influenza Vaccine Consent & Release Form

PATIENT INFORMATION (PLEASE PRINT)

Please notify the pharmacist if you are Pregnant, Immunocompromised, or 65 years and older.

Last Name | First Name | M.I. | Date of Birth

Last 4 digits of Social Security # | Gender (F, M, Decline, Other) | Phone Number | E-Mail

Street Address | City | State | ZIP code

PHYSICIAN INFORMATION

Please provide your Primary Care Physician's information if available.

Name of Primary Care Provider | PCP Phone Number:

MEDICARE INFORMATION

Please provide your Medicare Part A or B ID # if available.

Yes / No
Do you have Medicare?

Medicare Part A or B ID#
(ex: 1EG4 - TE5 - MK73)

INSURANCE INFORMATION

Please provide your Drug insurance, Primary insurance, and Secondary insurance information if available.

Primary Insurance Name | Primary Insurance Cardholder ID # | Primary Cardholder Full Name | Primary Relationship to Cardholder (Self / Spouse / Dependent) | Primary Cardholder DOB

Secondary Insurance Name | Secondary Insurance Cardholder ID # | Secondary Cardholder Full Name | Secondary Relationship to Cardholder (Self / Spouse / Dependent) | Secondary Cardholder DOB

If applicable on insurance card, please provide your RX BIN, RX GROUP, and RX PCN numbers. →

RX BIN | RX GROUP | RX PCN

CONSENT & SIGNATURE

Please read then print and sign below. This may be completed by the vaccine recipient, parent, legal guardian, POA, or authorized signer. Please see a pharmacy staff member if you have any questions.

I consent to receiving the above vaccine from Times Pharmacy. I understand that I am giving Times permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company, as applicable, to enable Times to process my insurance claims with respect to the vaccination. I understand that if my insurance does not pay for the services rendered on this form, I am responsible for payment. I, for myself, my heirs, executors and assigns hereby release Times and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with this vaccination. I also acknowledge that I received a copy of the Vaccine Information Statement (VIS) for the vaccine stated below and that I understand the benefits and risks associated with the described vaccine.

(Please Print) Recipient/Parent/Legal Guardian/POA Name/Authorized Signer

x
(Please Sign) Signature of Recipient/Parent/Legal Guardian/POA/Authorized Signer

Date

Recipient Name: _____

Date of Birth: _____

Age: _____ Temperature: _____

Times Pharmacy Flu Pre-Vaccination Screening Form

1) Are you sick today (currently experiencing fever over 100 °F, difficulty breathing, cough, etc.)?

☐ Yes ☐ No ☐ Don't Know

2) Have you had any of these symptoms in the last 14 days (fever or chills, shortness of breath or difficulty breathing, cough, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea)?

☐ Yes ☐ No ☐ Don't Know

3) Have you had contact with anyone with confirmed COVID-19 in the last 14 days?

☐ Yes ☐ No ☐ Don't Know

4) Have you received a flu shot in the past 5 years?

☐ Yes ☐ No ☐ Don't Know

5) Do you have allergies to medications, food, a vaccine component, or latex?

☐ Yes ☐ No ☐ Don't Know

If Yes – Specify Allergy and Allergic Reaction: _____

6) Have you ever had a serious reaction after receiving a vaccination?

☐ Yes ☐ No ☐ Don't Know

If Yes – Specify Vaccine and Serious Reaction: _____

7) Do you have a history of Guillain-Barre syndrome? (severe temporary muscle weakness)

☐ Yes ☐ No ☐ Don't Know

I attest that the statements on this pre-screening form are accurate and truthful to the best of my knowledge:

Self / Parent of a Minor / Legal Guardian / Power of Attorney / Authorized Signer

(Circle One) Relationship to Vaccine Recipient

_____ _____

Print Name **Signature**

----------*** FOR OFFICE USE ONLY ***----------

Vaccine Administrator	Vaccine	Site/Route	Place Vaccine Sticker Here (Vaccine, Dose, Lot #, Expiration, Manufacturer)	Date Administered	Vaccinator Name & Signature
Times Pharmacy Mobile Clinic	Flu Vaccine	Left Arm IM Right Arm IM			