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PHARMACY + CLINIC

Influenza Vaccine Administration Record Informed Consent Form

Please PRINT the information for the patient receiving the vaccine in the space provided below:

First and Last Name _____ **Date of Birth** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip** _____ **Gender:** _____

Phone # _____ **Email** _____

Physician's Name _____ **Physician's Address** _____

Please answer the questions below:

1.	Are you sick today?	☐ **Yes**	☐ **No**	☐ **Don't know**
2.	Do you have allergies to medications, food (e.g., eggs), yeast, a vaccine component, or latex? If yes, please list: _____	☐ **Yes**	☐ **No**	☐ **Don't know**
3.	Have you ever had a serious reaction (including fainting) after receiving a vaccination?	☐ **Yes**	☐ **No**	☐ **Don't know**
4.	Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside a medical setting?	☐ **Yes**	☐ **No**	☐ **Don't know**
5.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐ **Yes**	☐ **No**	☐ **Don't know**
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease?	☐ **Yes**	☐ **No**	☐ **Don't know**
7.	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐ **Yes**	☐ **No**	☐ **Don't know**
8.	Have you had a seizure or a brain or other nervous system problem or Guillain-Barré?	☐ **Yes**	☐ **No**	☐ **Don't know**
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ **Yes**	☐ **No**	☐ **Don't know**
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐ **Yes**	☐ **No**	☐ **Don't know**
11.	Have you received any vaccinations in past 4 weeks?	☐ **Yes**	☐ **No**	☐ **Don't know**

I certify that I am at least 18 years old or that I am the parent or legal guardian of the minor patient (6-17 years of age for influenza only) or the legal guardian of the patient. I hereby give my consent to the staff of Sona Pharmacy to administer vaccine(s) that I have requested. I understand that is not possible to predict all possible side effects or complications associated with vaccines. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance ask questions. I, on the behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns herby agree to release, indemnify, and hold harmless Blue Ridge Pharmacy, Inc., its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed above. I authorize Blue Ridge Pharmacy, Inc., as applicable, to release my medical or other information to, or through, the NC Immunization Registry to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, submit a claim to my insurer for the above requested vaccine(s), and request payment of authorized benefits to be made on my behalf to Blue Ridge Pharmacy, Inc., as applicable, with respect to the above requested items and services. **I further agree to be fully financially responsible for any co-sharing amounts, including copays, co-insurance, and deductibles, for the requested vaccine(s) including any not covered by my insurance benefits. I understand that if my insurance denies my claim for any reason, I will receive a bill for the above requested vaccine(s) from Blue Ridge Pharmacy, Inc.**

Signature:_____ **Date:**_____

(Parent or Guardian, if patient is a minor)

Print Form (double sided) **Clear Form**

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PHARMACY STAFF ONLY							
Vaccine	**Route (circle route)**	**Dose Administered (circle dose)**	**Injection Site**	**Lot #**	**Exp Date**	**VIS Published Date**	**Date Vaccine and VIS Provided**
Influenza (MDV/prefilled) Alfuria® MDV or PFS (Quad)	IM	0.5mL	R L arm	P100230204	6/7/2021	8/15/19	
Influenza (nasal)	IN	0.1mL/nostril	R and L nostril			8/15/19	
Influenza (65+) Fluad®	IM	0.5mL	R L arm	279784	5/13/2021	8/15/19	

Immunizer Name (Print):_____

Immunizer Signature:_____

Intern Name (Print):_____

Intern Signature:_____

Documented within 72 hours: ☐ Faxed provider

Place Pharmacy Prescription Label Here/Rx Number