Flu and Pneumonia Vaccine Informed Consent Form 2017-2018

__Medicare
__Cash
__AR
__Credit
__Other

Buckley's Drug Store
35 E. Palisade Ave.
Englewood, NJ 07631
www.bucklevsrx.com
Tel: 201-569-1345
Fax: 201-568-5354

_____
Last Name (Print) First Name (Print)

_____
Street Address (Print)

_____(_____) _____
City, State, Zip Code (Print) Phone Number

Email:_____(To receive information for future vaccine information)

Sex: _____M_____ F Date of Birth:____/____/ _____ mm/dd/yyyy Age:_____Vaccine: Flu Pneumonia

I, _____, have read or had explained to me by Buckley's Pharmacy Staff the attached information about the vaccine. I have had an opportunity to ask questions about the vaccine which were answered to my satisfaction, and I am 18 years of age or older. I have been informed of the Notice of Privacy Practices

Adult Immunization Screening for Inactivated Influenza	**Check Y or N**
1. Are you moderately or severely ill today? (e.g. fever, respiratory illness)	Y N
2. Have you ever had an adverse reaction to a previous dose of :	
• Influenza (flu) vaccine?...	Y N
• Another Vaccine?	Y N
3. Have you ever had an adverse reaction to:	Y N
• Chicken egg or egg protein, Chicken or feathers?.....	
• Thimerosal (a preservative found in some vaccines and some contact lens solutions?.....	Y N
4. Have you ever had:	
• Guillain-Barre Syndrome (an illness with sudden muscle weakness?)	Y N
• Active, unstable neurological disorder	Y N

I understand that serious injury or death can result from any vaccination and in consideration of receiving the vaccination(s) checked above, voluntarily assume the risk of and accept full liability for any and all injuries and death which may occur as a result of my vaccination(s). I agree release Carlbert Drugs Inc., d/b/a Buckley's Drug Store its agents, representatives, employees, servants, officers, successors and heirs from any and all liability for giving me (or the individual on whose behalf I am signing) the pneumococcal vaccination. I agree to indemnify, defend, and hold the Indemnities harmless from any claim made by any person (including the individual on whose behalf I am signing). I understand there is no assurance that the vaccine will prevent the flu or . I have been explained the benefits and possible side effect of the vaccine and request that the vaccine be given to me.
My signature on this form means that all of the information provided in this Application and consent form are true to the best of my knowledge. I understand that this form and my signature below are binding on me and my heirs, successors and personal and legal representatives as well as those of the person on whose behalf I am signing. If I am not the person being vaccinated, I warrant that I have the authority to give this consent for the person to be vaccinated.
The most common reactions that occur after receiving the vaccine are a sore or tender arm with slight redness at the injection site.

Participant Signature:_____**Date:**____/____/_____ _____

Legal Guardian Name **Relationship to Minor** **Phone**

Part B Section- Medicare Recipients Only

Medicare Number ---------- Letter Suffix _____

I am not a member of an HMO (Health Maintenance Organization). I.e. Senior Plus, HAP and Secure Horizon. I attest that Medicare Part B is my Primary Medical Coverage and that I will be billed for the charges of $30 or $65 for the High Dose for the flu vaccine should Medicare reject my claim shot.

Signature_____

$	VACCINE	Lot #	Dose	Route/Site
$65.00	High Dose Flu	UI1840AA	0.5 ml	IM ARM R L
$30.00	Fluvirin		0.5 ml	IM ARM R L
	Fluzone Quad	U5896CA	0.5 ml	IM ARM R L
$80.00	Pneumovax/Prevnar		0.5 ml	IM ARM R L

Health Care Provider:_____ Date:_____/_____/____ Time : AM PM