PARKER PHARMACY INC.
Your Wellness Center
1368 Hertel Ave. 725-0887

Influenza Immunization Consent Form

Name: _____ Date: _____ Sex (please circle): (M / F)

DOB: _____ Age: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Provider: _____ ID: _____

Group: _____ Person Code: _____

I hereby agree to allow entry of this vaccination onto the NYS Immunization registry.
☐ Yes ☐ No

Please complete the questions below:

☐ Yes ☐ No Are you currently sick or do you have a fever?
☐ Yes ☐ No Have you ever had an allergy to any component (or part) of the flu vaccine? If yes, please describe:
☐ Yes ☐ No Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?
☐ Yes ☐ No Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:
☐ Yes ☐ No Are you allergic to eggs or egg products?
☐ Yes ☐ No Are you currently pregnant?
☐ Yes ☐ No Are you taking blood-thinning medication?
☐ Yes ☐ No Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?
☐ Yes ☐ No Have you received any other vaccinations within the last 4 weeks?
☐ Yes ☐ No Have you taken an antiviral medication for the flu within the last 48 hours?

Influenza Consent

I have read, or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a change to ask questions, which were answered to my satisfaction, and I under stand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me. I authorize the release of any medical or other information necessary to process a Medicare of other insurance claim or for other public health purpose.

_____
Signature of Recipient Date

Area Below To be Completed By Pharmacist

Administration Date: _____
Administration Site: ☐LD ☐RD ☐LT ☐RT
Manufacturer & Lot #: _____
Expiration Date: _____
VIS Date: _____
Administered By: _____