COPAY PAID:
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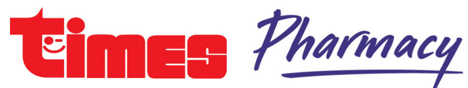

Vaccination Consent and Release Form

STORE#:______

PATIENT INFORMATION (PLEASE PRINT)

If you are pregnant, 65 years and older, or immunocompromised - please notify the pharmacist

Last Name:	First Name & Middle Initial:	DOB:	Gender: M or F
Home Address: City: State: ZIP:		Daytime Phone:	
Mother's Maiden Name (optional):			

PHYSICIAN (M.D.) INFORMATION

Please provide your Primary Care Physician's information

M.D. Name: (Last Name, First name)	M.D. Office Location: (ex: Straub, Queens, etc.)	M.D. Phone:

INSURANCE INFORMATION

Do you have Medicare Part B?	If yes, Medicare Part B#:	
Plan Name:	Membership or Subscriber #:	Group #:
Relationship to Subscriber Self / Spouse / Child	Subscriber Name (if other than self):	Subscribers DOB:
IF APPLICABLE ON INSURANCE CARD:	BIN #:	PCN #:

The following questions will help us determine if you are eligible or not eligible to receive the Inactivated Influenza Vaccine.

	Please answer the questions by checking the boxes.	YES	NO	DON'T KNOW
1.	Have you received a flu shot in the past 5 years?			
2.	Do you have a fever or are you ill today?			
3.	Have you ever had a serious reaction to eggs or to a component of any flu vaccine?			
4.	Have you ever had a serious reaction to a previous dose of flu vaccine or other vaccine?			
5.	Have you ever had Guillain-Barre Syndrome (a temporary severe muscle weakness)?			
6.	Do you have a sensitivity to latex?			

I consent to receiving the following vaccine from Times Pharmacy. I understand that I am giving Times permission to release any medical or other necessary information to my physician, Medicare, or other 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 the most current 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.

Patient Signature **Date**

VACCINE INFORMATION to be completed by the Pharmacist

Affix vaccine information sticker HERE

SITE OF INJECTION : IM – Left arm / Right arm (circle)

Pharmacist Signature Date