INACTIVED INFLUENZA (FLU) VACCINE ADMINISTRATION CONSENT FORM (v8.2024)

First Name:_____ **Last Name:**_____ **Gender:** ☐ *Female* ☐ *Male*
Date of Birth:_____ **Phone:**_____
Home Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Doctor/PCP:_____ **Phone:**_____ **Fax:**_____
Drug allergies:_____

1) Do you have Medicare Part B? Y or N **2) Medicare Parts A/B alphanumeric number or SS#**_____

Please provide your ID and all of your medical, supplemental and prescription insurances to the staff.

These questions help determine your eligibility for vaccination	**YES**	**NO**
1. Do you have a fever >101^{o}, an infection, diarrhea, or vomiting today?		
2. Are you allergic to eggs, Baker's yeast, preservatives (i.e. sulfites),thimerosal, streptomycin, neomycin, or latex? Please list allergies here:_____		
3. Have you ever had a severe reaction to any vaccine which required medical care?		
4. Have you ever fainted or felt dizzy after receiving a vaccine?		
5. Have you had Guillain-Barre Syndrome, a condition which causes paralysis?		
6. Are you taking any blood-thinning medications (i.e. aspirin, warfarin, etc)?		
7. Have you been exposed to anyone positive OR suspected positive for COVID 19 in the last 14 days?		
8. Would you like your vaccine administration reported to the Texas Immunization Registry?		

NOTE: Answering yes to any of questions #1-3 or #5 may warrant referral to a physician for further evaluation to determine appropriateness of the vaccination

CONSENT/AUTHORIZATIONS: I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian/POA of the Patient. Additionally I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from Liberty Pharmacy , the "Facility", including but not limited to qualified pharmacists and pharmacy technicians. I understand that these providers may perform services at various locations such as within a mobile or another healthcare setting, i.e., a pharmacy, senior home, or long-term care facility. I understand that it is not possible to predict all possible side effects or complications associated with receiving the requested vaccine. I understand the risks and benefits associated with the vaccine and have received, read and/or had explained to me the Vaccine Information Statement. I additionally acknowledge that I have received a copy of the Facility notice of privacy practices. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. I further authorize the Facility to (1) release my medical records or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the requested items and services, and (3) request payment of authorized benefits be made on my behalf to Liberty Pharmacy with respect to the requested items and services. If my medical insurance coverage is not accepted by the Facility, I authorize Liberty Pharmacy to bill my prescription insurance for these services instead. I further agree to be fully financially responsible for any co-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of services or, if invoiced after the time of services, upon receipt of such invoice. I understand that in the course of the requested vaccine administration, a Facility representative could possibly be exposed to my blood or bodily fluids. In such event, I agree to review and execute the Facility Post-exposure Consent for Testing form.

WAIVER/INDEMNITY: On behalf of myself, my heirs and personal representatives, I further hereby both WAIVE/RELEASE and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) any and all healthcare providers of Liberty Pharmacy, its staff, agents, supervising doctors, owner and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of services even should such damages or losses result from negligence.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Guardian Signature and relation to patient **Date**

VACCINE INFORMATION (Office use only)

FLUCELVAX (SEQIRUS) /FLUARIX (GSK) FLUAD (SEQIRUS)	_____	__/__/__	0.5ml	IM
Vaccine	Lot #	Exp. Date	Dose (ml)	Route

Right or Left Deltoid	__/__/__	08/6/2021	MufidN/KunalN/JillianB/HugoB/Brandy W/VanessaG/AdrianaS
Admin. Site	Admin. Date	VIS Date	ADMINISTRATOR