RX#____________

Daly Drug – Vaccine Administration Record

Patient Name ____________________________________

Date of Birth _____________Age ____ Male/Female_______

Address ____

Phone _____________________________________

<u>If enrolled in Hospice, contact your RN to determine coverage PRIOR to Injection.</u>

Insurance _______________________________________

Member ID ______________________________________

Group # ____

Bin # ____

PCN# ____

EMPLOYEE________ FACILITY NAME____________________________

Consent: Most commonly, the reactions may be sore or tender arm at the injection site if given a shot, or possibly fever, chills, headache or muscle aches. Symptoms usually last between 24-48 hours. I release Daly Drug from responsibility of any reaction resulting from the injection and I take full responsibility to seek medical attention should more severe symptoms occur. I acknowledge I have no contraindications listed in the "Screening Checklist" that would prevent me from receiving an influenza vaccination at this time.

I have read, or had explained to me, the 2020-2021 Vaccine Information Statement for the seasonal flu vaccine and understand the risks and benefits.

I give consent to Daly Drug to administer the 2020-2021 Seasonal Influenza Vaccine.

Signature ____________________________________Date_____________

Parent / Guardian _____________________________________

Vaccine ______________ Lot _____________ Exp. Date __________ Inj. Site ________