

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Date of Birth: _____

Sex: ☐ Male ☐ FemalePreference: ☐ Left Arm ☐ Right Arm

Vaccine Requested: ☐ COVID ☐ Flu ☐ Pneumonia
☐ Senior RSV ☐ Shingles ☐ Tetanus/Tdap

	Yes	No	Don't Know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem or take medications that affect your immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet or patient fact sheet corresponding to the vaccine that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to me.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Stauffer's Drug Store to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Stauffer's may be required to or may voluntarily disclose my health information to the physician responsible for this protocol, my Primary Care Physician, my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations.

X _____

Signature of patient

Date