

RX #: \_\_\_\_\_

## Daly Drug – Vaccine Consent Form

RX #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

RX #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male/Female: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Are you a facility employee? (Circle one:) Yes / No

**If enrolled in Hospice, contact your RN to determine coverage PRIOR to Injection.**

**Medicare #:** \_\_\_\_\_

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*All insurance information is needed for all non-Daly Drug patients.*

**Insurance:** \_\_\_\_\_

Member ID # \_\_\_\_\_

Group # \_\_\_\_\_

Bin # \_\_\_\_\_

PCN # \_\_\_\_\_

**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 a vaccination at this time.

I authorize Daly Drug to release information and request payment. I certify the information given is correct and accurate in applying for payment under Medicare or Medicaid. I understand Daly Drug may be required to or may voluntarily disclose health information to my Primary Care Physician, my insurance plan, health systems and hospitals, and State or Federal registries for purposes of treatment, payment or health care operations.

I have read, or had explained to me, the 2024-2025 Vaccine Information Statement for the vaccine(s) I am consenting to receive and understand the risks and benefits.

***I give consent to Daly Drug to administer the following vaccine(s):***

- COVID-19     \*Booster # \_\_\_\_     Pneumococcal     Td/Tdap
- Influenza (Flu)     RSV     Shingles \*Dose # \_\_\_\_     Other \_\_\_\_\_

\*Required

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent / Guardian \_\_\_\_\_