RX #:_____

Daly Drug – Vaccine Consent Form

RX #:_____

RX #:_____

Patient Name: _____

Date of Birth: _____ Age: _____ Male/Female: _____

Address: _____

Phone: _____

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

Medicare #: _____

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 2025-2026 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 ☐ RSV ☐ Pneumococcal ☐ Td/Tdap

☐ Influenza (Flu) ☐ Shingles *Dose # ___ ☐ Other _____

***Required**

Signature _____ Date _____

Parent / Guardian _____