**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

**Medicare #:** _____

(Write in both letters & numbers. Ex**: 1EG4-TE5-MK72)**

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

**Name of Insurance:** _____

Member ID # _____

Group # _____

Bin # _____

PCN # _____

**Consent:** Most commonly, the reactions may be sore or tender arm at the injection site, 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 2026-2027 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 _____

Signature _____ Date _____

Parent / Guardian Name & Signature _____

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