CVS CAREMARK

Address _____

City, State, Zip _____ Telephone _____

Inactivated Influenza Vaccine Consent and Administration Record

Pharmacist Immunization Program

Information about patient receiving vaccination (Please print):

Last Name	First Name	Middle Init.	Date of Birth	Sex
			/ /	M / F
Street	**City**	**State**	**Zip**	**Phone #**
Medical Condition(s)		**Allergies**		
Primary Care Physician (PCP)		**PCP Contact Information**		

Please answer the following questions:	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	☐	☐	☐
2. Do you have allergies or reactions to medications, foods or any vaccine? (For example: eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please list_____	☐	☐	☐
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	☐	☐	☐
4. Have you had a seizure, brain, or other nervous system problem? (For example: Guillain-Barré syndrome)	☐	☐	☐
5. For women: Are you pregnant or nursing? Could you become pregnant during the next month?	☐	☐	☐

Please read the following statements and sign on the signature line below

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained 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 request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I voluntarily authorize and direct my health care provider at CVS/pharmacy to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at CVS/pharmacy (standing order provider_____), my Primary Care Physician (PCP), my insurance plan and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). This authorization permits CVS/pharmacy to disclose the following medical records: only documents related to the vaccination(s) received today. This Authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

I acknowledge that I have received the CVS/pharmacy Notice of Privacy Practices, which is provided on the back of the Patient copy of this consent form.

Medicare Billing: I do hereby authorize CVS/pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare 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.

X_____ **Date:** _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

This section to be completed by Pharmacy:

VACCINE ADMINISTRATION INFORMATION:

Date	Product	Manufacturer	Vol (mL)	Route	Site

Lot #	Exp. Date	VIS Version Date	Date VIS Given to Pt	Administering Immunizer Name & Title