Wellness Pharmacy Services

Influenza Vaccine Consent Form

❶ PATIENT IDENTIFICATION

Patient Name:	Date of Birth:
Address:	Gender:
City, State, Zip:	Phone #:

❷ SCREENING QUESTIONS

Have you received the flu vaccine before?
Severe reaction to the flu vaccine in the past?
Serious allergy to chicken eggs?
History of Guillian-Barre Syndrome (GBS)?

❸ INSURANCE INFORMATION – PATIENT OR FACILITY TO PROVIDE A COPY TO PHARMACY

□ I receive health insurance from this facility Name of facilty:_____

❹ CONSENT & RELEASE

By signing, I have received and agreed to the following:

- Received and read the vaccine information sheet (dated 8/6/21) regarding benefits and risks of receiving the Influenza vaccine;
- Had the opportunity to have questions answered regarding the vaccine;
- Consented to be immunized;

I hereby release Wellness Pharmacy Services, its employees, agents, representatives and assigns, including but not limited to the property owner upon which the event takes place, and its respective parent, subsidiary and affiliated companies, from any and all liability that may be associated with my receipt of the influenza vaccine.

Signature:	Today's Date:

VACCINE ADMINISTRATION INFORMATION FOR IMMUNIZER/PHARMACIST/NURSE ONLY

Administation Date:	Vaccine Type: □ Afluria 25/26 QIV □ Fluzone HD 25/26 (65+)	Lot#:
Route: □ Arm □ Leg Site: □ Left □ Right	Vaccine Expiration:	Patient Temperature:
Immunizer Name & Title:		Immunizer Signature: