INFLUENZA Immunization CONSENT FORM

Pharmacy

PATIENT INFORMATION

LEGAL NAME (print clearly): **FIRST**: _____ **MIDDLE INITIAL**: _____

LAST: _____ **SUFFIX** (Jr., Sr., etc.) _____

PHONE: (_____) _____-_____ **DATE OF BIRTH**: _____/_____/_____ **GENDER**: M F

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PRECAUTIONS AND CONTRAINDICATIONS:

1.	Age of patient. A prescription is required to administer vaccine if patient is **≤8 years old**	1. _____age of patient
2.	**For women**: Are you pregnant?	2. Yes _____ No _____
3.	Do you have a fever or illness today?	3. Yes _____ No _____
4.	Have you ever had a serious reaction after receiving a vaccination?	4. Yes _____ No _____
5.	Are you allergic to eggs, chicken protein, thimerosal, neomycin, polymyxin, gelatin, latex, yeast, or any other vaccine ingredients? If yes, please list: _____	5. Yes _____ No _____
6.	Have you experienced seizures, Guillain-Barré Syndrome or other neurological disorder after receiving a vaccine?	6. Yes _____ No _____

CONSENT FOR SERVICE: I certify that I am at least 18 years old and hereby give my consent to the staff of Kroger Pharmacy to administer the vaccine(s) indicated below. I have read the Vaccine Information Sheets(s) (VIS) for my vaccine and understand the benefits and risks of the vaccine and choose to assume that risk. As with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine(s). I fully release and discharge the standing order physician, and Kroger Limited Partnership I, dba Kroger Pharmacy, its affiliates and their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from. I acknowledge that I have received a copy of the Kroger Company privacy policies, in accordance with HIPAA. I acknowledge that I am in a high-risk group as defined by the CDC. (Applicable only when mandated by the CDC).

*** I agree to wait near the vaccination area for approximately 15-20 minutes to receive treatment in case of an adverse reaction.**

SIGNATURE (or signature of guardian if under 18) **X**_____

********** **For Pharmacy Use Only** **********

Influenza Vaccine 0.5ml IM _____ _____ Site: LD RD **VIS: 08/07/2015**
LOT # EXP. DATE

☐ 0.5ml IM Fluzone **QUADRIVALENT®** Sanofi Aventis (> 3 years) contraindications: allergies to eggs; THIMEROSAL in MDVs (not in PFS)

☐ 0.5ml IM Fluzone **HD®** Sanofi Aventis (> 65 years) contraindications: allergies to eggs

Immunizer: _____(PharmD/RPH/Intern) Date: 10/_____/2017

***********Place store stamp with address on back of this document*********