Stephens Pharmacy Consent Form / Vaccine Administration Record Inactivated Influenza Vaccination 2022/23

The Flu – Influenza is a respiratory infection caused by viruses. When people get the flu, they may have fever, chills, headache, dry cough, or muscle aches. Illness may last several days up to a week or more, and complete recovery is usual. However, complications may lead to death in some people.

The Vaccine – An injection of flu vaccine will NOT give you the flu. The vaccine is made from a dead virus. We recommend that you remain in the pharmacy for 15 minutes to monitor for possible adverse reactions.

Risks and Possible Side Effects – Side effects of the influenza vaccine are generally mild in adults and occur at low frequency. These reactions consist of tenderness at the injection site, fever, chills, headaches, or muscular aches. These symptoms last up to 48 hours. (An immediate, presumably allergic, reaction rarely occurs after a flu vaccination. This probably results from an allergy to some vaccine component, the majority most likely related to residual egg protein).

Please answer the following questions (circle):

1.	**Are you sick today?**	**YES**	**NO**
2.	**Are you allergic to eggs or egg product?**	**YES**	**NO**
3.	**Have you ever had a serious reaction to the flu vaccine in the past?**	**YES**	**NO**
4.	**Have you had, or are you at risk for Guillain-Barre syndrome?**	**YES**	**NO**

Consent: I have received and read, or had explained to me, the Vaccine Information Sheet for influenza vaccine. I understand the risks and benefits, and have been provided an opportunity to ask questions, and they have been answered to my satisfaction. I wish to receive the influenza vaccine and hereby give consent for Stephens Pharmacy to administer the influenza vaccine and communicate the administration of the vaccine to my primary care practitioner, who is listed below.

First and Last Name		Date of birth	Age	Gender
Street Address		**City, State, Zip**		
Phone #	**Drug/food allergies**	**Physician's name**	**City where physician located**	
Signature of person receiving vaccine		**Today's Date**		
X				

PLEASE NOTE: We can only file for Medicare Advantage and Private Insurances Contracted with Stephens Pharmacy. Please let us know if you have a Primary insurance other than Medicare Part B.
For Medicare Part B accepted Stephens Pharmacy Insurance Beneficiaries <u>Only:</u> I authorize Stephens Pharmacy to bill Medicare on my behalf. I understand that if Medicare denies my claim for <u>any reason</u> (including but not limited to other coverage, incorrect date of birth, or prior claim submission this year) I may be billed by Stephens Pharmacy.

Medicare Patient Signature:	**Medicare ID Number**										
X											

Stephens Pharmacy
1101 Main Street
Honesdale, PA 18431

Cash / Check / Credit Card / Medicare / Ins.

Vaccine Manufacturer and Lot #_____

Exp Date_____ Injection Site: L R arm

RPh Signature /Date_____