COPAY $_____
COPAY PAID: Y / N
BUSINESS/PATIENT

times Pharmacy

STORE#: _____

Influenza Vaccine Consent & Release Form

PATIENT INFORMATION (PLEASE PRINT)

If you are Pregnant, Immunocompromised, or 65 years and older, please notify the pharmacist.

Last Name:	First Name:	Date of Birth:	Age:
Home Address: City: State: ZIP:		Gender: M / F	
Daytime Phone:	Employer Name: (For Business Clinics)		

PHYSICIAN (M.D.) INFORMATION

Please provide your Primary Care Physician's information if available.

M.D. Name: (last name, first name)	M.D. Office Location: (ex: Straub, Queens, Kaiser, etc.)	M.D. Phone:

INSURANCE INFORMATION

Please provide all current insurance information for processing your claim.

REQUIRED FOR 65 AND OLDER Please provide last 4 digits of SS# __ __ __ __	Do you have Medicare? ☐No (ex: 1EG4 - TE5 - MK73) ☐Yes ID #: __ __ __ __ - __ __ __ - __ __ __ __	
Insurance Name: (ex: HMSA, Kaiser, Tricare, UHA, etc.)	Membership or Subscriber ID #:	Group #:
Subscriber Name: (if other than self)	Subscriber's Date of Birth:	Relationship to Subscriber: Spouse / Dependent
IF APPLICABLE ON INSURANCE CARD	Rx BIN #:	Rx Group #:	Rx PCN #:

The following questions will help us determine if you are eligible to receive the Inactivated Influenza Vaccine today.				
	Please answer each question by checking a box.	YES	NO	DON'T KNOW
1.	Have you received a Flu shot in the past 5 years?	☐	☐	☐
2.	Do you have a fever or are you sick today?	☐	☐	☐
3.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
4.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
5.	Do you have a history of Guillain-Barre syndrome? (severe temporary muscle weakness)	☐	☐	☐

I consent to receiving the following vaccine from Times Pharmacy. I understand that I am giving Times permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company, as applicable, to enable Times to process my insurance claims with respect to the vaccination. I understand that if my insurance does not pay for the services rendered on this form, I am responsible for payment. I, for myself, my heirs, executors and assigns hereby release Times and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with this vaccination. I also acknowledge that I received a copy of the Vaccine Information Statement (VIS) for the vaccine stated below and that I understand the benefits and risks associated with the described vaccine.

_____ _____

Patient Signature **Date**

FLU VACCINE INFORMATION to be completed by Pharmacist

VIS:

Affix vaccine information sticker HERE

SITE OF INJECTION : IM – Left arm / Right arm (circle)

_____ _____

Pharmacist Signature **Date**