CONLIN'S PHARMACY, INC. INFLUENZA VACCINATION CONSENT

Vaccine Recipient Information Required

Last Name	First Name	MI	DOB	Age

Street Address	Apt

City	State	Zip	Email	Gender

Phone Number	Cell Phone	Social Security

Vaccine Recipient Insurance Information Required

*Do you have Prescription Insurance? Yes ☐ No ☐	*Are you the primary cardholder? Yes ☐ No ☐
*Prescription Benefit Plan Name:	If no, provide primary card holder's DOB:

*Cardholder ID #:	RX Group ID Located on Insurance Card	Bin Located on Insurance Card	PCN Located on Insurance Card

Are you age 65 or older or Medicare Eligible? Yes ☐ No ☐	Medicare Part A/B ID Number

Medical Insurance:	Cardholder ID #:	Group ID:

Are you the primary cardholder? Yes ☐ No ☐	If no, provide primary card holder's DOB:

Screening Questions (All questions below must be answered.)	YES	NO	DON'T KNOW
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever had an allergic reaction to food, pet, environment, or oral medication? Allergies: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
3. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
4. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
5. Have you received any vaccine in the last 4 weeks?	☐	☐	☐
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
7. Are you pregnant or breastfeeding?	☐	☐	☐

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Screening Questions Continued (All questions below must be answered.)	YES	NO	DON'T KNOW
8. Do you have any of these symptoms that are not caused by another condition? • Fever or Chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • Recent loss of taste or smell • Sore Throat • Congestion • Nausea or vomiting • Diarrhea	☐	☐	☐
9. If you are not fully vaccinated, have you been in close contact with anyone with COVID -19 in the past 14 days? Close contact is being within 6 feet for 15 minutes or more over a 24-hour period with a person; or having direct contact with fluids from a person with COVID-19 with or without wearing a mask (i.e., being couched or sneezed on).	☐	☐	☐
10. Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting the results of a COVID-19 test?	☐	☐	☐
11. Within the past 14 days, has a public health or medical professional told you to self-monitor self-isolate, or self-quarantine because of concerns about COVID-19 infection?	☐	☐	☐

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Conlin's Pharmacy, Inc. to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid 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.

DISCLOSURE OF RECORDS: I understand that Conlin's Pharmacy, Inc. may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Conlin's Pharmacy, Inc., my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Conlin's Pharmacy, Inc. will use and disclose my health information as set forth in the Notice of Privacy Practices (copy available in-store, online or by requesting a paper copy from the Pharmacy).

I authorize Conlin's Pharmacy, Inc. to share my vaccination data with MIIS Registry.

X	
***Signature of patient to receive vaccine (or parent, guardian, or authorized representative)** If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.	DATE

Print name of parent, guardian, or authorized representative	Phone Number	Relationship

** PHARMACY USE ONLY **

Vaccine Name	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name of Vaccinator
☐ Afluria	☐ IM - L Arm		☐ Seqirus		
☐ Fluzone	☐ IM - R Arm		☐ Sanofi Pasteur		
☐ Fluzone HD					
☐ Flucelvax MDV/PFS					

*Pharmacist reviewing this form:	Pharmacist Signature:
Vaccinator Name:	Vaccinator Signature: