Vaccine Administration Record
Waiver/Consent Form

PARTICIPANT INFORMATION AND CONSENT

LAST NAME:	FIRST NAME:	MI:	BIRTHDATE: MM/ DD/YYYY	
ADDRESS:	CITY:	STATE:	ZIP:	PHONE: ( )
PRIMARY CARE PHYSICIAN (PCP): ❒ I do not have a PCP		PROVIDER PHONE:		
Email address *(optional)*:				
Please check the vaccine(s) interested in receiving: ❒ Flu ❒ Pneumonia ❒ Tdap ❒ Other ____________				

	Question	Yes	No
1.	Do you have or have you ever had allergies or a serious reaction to vaccines (including Guillain-Barre Syndrome), medications (including neomycin or polymxin), food (including eggs), or the preservative thimerosal? If yes, please list here: ____	❒	❒
2.	Do you have chronic illnesses or any conditions that may affect your immune system? If so, please list here: _______________________________	❒	❒
3.	Do you feel sick today or do you have a fever?	❒	❒
4.	If you are female, are you pregnant? # Weeks______	❒	❒
5.	Are you 65 years of age or older?	❒	❒
6.	Do you smoke, have asthma, or any other lung condition?	❒	❒
7.	If you answered yes to #5 or 6, have you had a pneumonia vaccination?	❒	❒

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Immunize RX, an agent of Nicholson's Sumner Pharmacy and Cornerstone Medical Clinic, as applicable, to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statement(s) on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Immunize RX, Nicholson's Sumner Pharmacy and Cornerstone Medical Clinic, as applicable, any staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I authorize Immunize RX, an agent of Nicholson's Sumner Pharmacy and Cornerstone Medical Clinic, as applicable, to (1) release my medical or other information, including my communicable diseases (including HIV), mental health, or drug/alcohol abuse information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (2) submit a claim to my insurer for the above requested items and services, and (3) request payment of authorized benefits be made on my behalf to Immunize RX, Nicholson's Sumner Pharmacy, or Cornerstone Medical Clinic, as applicable, with respect to the above requested items and services. I further agree to be fully financially responsible for any amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if Immunize RX, an agent of Nicholson's Sumner Pharmacy and Cornerstone Medical Clinic, invoices me after the time of service, upon receipt of such invoice.

Signature/Legal Guardian: **DATE:**

FOR CLINIC USE ONLY

PAYMENT INFORMATION:
CA______ (total $) CK_________ (chk#) CC______ (total $) Co. Sponsor_____________ (Co. Name) INS_______(fill out below)

HEALTH INSURANCE PROVIDER: **ID #:**

Relationship to Cardholder : Self Spouse Child (circle one) 1st 2nd 3rd

Information on Insurance card:
BIN # RxGROUP # PCN #

DOSE/ROUTE: 0.5cc/IM	MFG	LOT	EXPIRATION DATE	VIS DATE	SITE: Deltoid/Gluteal
Influenza CPT: 90658 Q2037 V04.81				8/7/2015	R / L
Pneumonia CPT: 90732 V03.82				4/4/2015	R / L
Tdap (Whooping Cough) CPT: 90715 V06.1				2/24/2015	R / L

SIGNATURE/TITLE OF VACCINATOR: DATE Vaccinated/VIS Given: