Immunization Consent Form Salmon Pharmacy Idaho 309 Main Street, Salmon, Idaho 83467

Name: Last First M.I.		Birth date:	Age:	Sex:
Street Address:	City:	County:	State:	Zip Code:
Home Phone Number:	Primary Care Physician:		Did you get a flu shot last year? YES NO	

Precautions and Contraindications:

All Vaccines:

1. Do you have a fever or are you sick today? Yes___ No___
2. Do you have allergies to medications, including neomycin, polymixin, thermisol, food, or any vaccine? Yes___ No___
3. Have you ever had a serious reaction to any vaccine? Yes___ No___
4. Do you have any chronic conditions? Yes___ No___
5. Have you ever had Guillan Barre Syndrome? Yes___ No___

Insurance information

Card BIN#_____ Card ID#_____Card PCN#_____Card RX Group #_____

Consent For Service: I hereby give my consent to the staff of Salmon Pharmacy to administer the Vaccine(s) indicated below. I have read the Vaccine Information Sheet (VIS) for my vaccine(s) 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 orders physician and Salmon Pharmacy, its affiliates wand their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from. I acknowledge that I have been informed of Salmon Pharmacy's privacy policies, in accordance with HIPAA. I hereby consent to the release of medical information when necessary for billing, and medical protocol **including applicable state immunization information systems.** I understand that a photocopy of this release is as valid as the original. I am aware of the Pharmacy's billing policy and I am responsible for the billing amount**. I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Signature of Patient or Legal Guardian:

X_____

**********Do Not Write Below This Line**********

Vaccine (Brand)_____0.5ml IM or 0.25ml IM Lot #:_____Exp. Date:_____

Volume 0.5 (flu/pneum) or 0.65 (zost)ml_____ Route: IM SQ

VIS Date: Today's Date:_____Site:_____Immunizer: _____

Check one:

Cash Pay ___Commercial Insurance___UTWF___Medicare____Medicare Part B#_____