ALL fields in shaded box must be completed

Pharmacists You Know, Care You Can Trust.

Vaccine Administration Record and Consent

ALL fields in shaded box must be completed

Name: _____ **DOB:** _____/_____/_____ **Gender: M / F**

Phone Number: (_____) _____-_____ Address: _____ **City:** _____

State: _____ **ZIP:** _____ **Food/Drug Allergies:** _____

Primary Care Physician: _____ **Physician Address:** _____

Medicare Part B: Y / N If yes, Name as it appears on Card: _____

Medicare #: (_____-_____-_____ **)**

I consent to the administration of the following vaccine(s):

□Flu Shot □ High Dose Flu Shot □ Preservative Free Flu Shot □ Pneumonia □ Shingles □ Tetanus □ Other: _____

Please place an X in the box to help determine if the vaccine(s) may be given today	YES	NO	Explain
1. Are you sick today? (Do you have fever, diarrhea, or have you vomited?)			
2. Have you ever had a severe reaction to any vaccine?			
3. Are you allergic to eggs, thimerosal, Streptomycin, or neomycin?			
4. Have you had a seizure or a brain disorder or other nervous system problem?			
5. Do you have gullain-barre syndrome? (a condition that causes paralysis)			
6. Do you have any other chronic health conditions like Asthma or Diabetes?			
7. Have you had a pneumococcal vaccine? (pneumonia shot)			
8. Have you had a tetanus, diphtheria, and pertussis vaccine in the last 10 years?			
9. For Women: Are you pregnant or is there a chance you could become pregnant in the next month?			
10-12 For Live Vaccines Only			
10. Have you received any vaccinations in the last 4 weeks?			
11. Do you or another member of your household have cancer, leukemia, HIV/AIDS, or other immune system problem?			
12. Do you take any medications that may affect your immune system like steroids or immunosupressants?			

I have read, or have had explained to me, the information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and authorize the administration of the vaccine to me or the person named below for whom I am authorized to make this decision.

I, for myself, my heirs, and executors release Schnucks Pharmacy as the Medicare provider, any retail or external site, physician, and employees, from any and all claims arising out of, or in any way related to my receipt of this or these immunization(s). Schnucks and the aforementioned related parties shall not at any time or any extent be liable or responsible for any loss, injury, death, or damage to be suffered or sustained at any time as a result of this vaccination program.

I consent to the release of this information to the Missouri Vaccine Registry (ShowMeVax) and my Primary Care Physician (as listed above) to document receipt of vaccination.

I agree to wait in the vaccination location for approximately 15 minutes for observation after vaccination.

I request that payment of authorized Medicare and/or private insurance benefits be made on my behalf to Schnucks for any services furnished to me in connection with Schnucks. I authorize any holder of medical or other information about me to release to and/or receive from the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits for related services. I understand that Schnucks reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. I agree to assume responsibility for payment for services and/or products furnished to me by Schnucks which are not paid to Schnucks for any reason by Medicare and/or any other medical insurance. I have received and understand my Medicare DMEPOS Supplier Standards and Notice of Privacy Practices. In addition, I agree that Schnucks may contact me in the future, via telephone or other means of communication, regarding ordering medical supplies.

Signature: _____ Date: _____

For Pharmacy Use Only:

Vaccine Name	Lot #	Quantity (mL)	MFG	Exp Date	Injection Route	Date Vaccine/ VIS Given	Injection Site	Date on VIS	Date NOV sent to PCP
Place RX Label here									Date entered in ShowMeVax

Vaccine Administered by: _____ **Date:** _____ **Location:** _____