IMMUNIZATION SCREENING AND CONSENT FORM



PATIENT INFORMATION

ADDRESS STATE STAT												
PATIENT'S PHONE # PRIMARY CARE PROVIDER PROVIDER PHONE/FAX ETHNICITY: Hispanic or Latino Not Hispanic or Latino Unknown RACE: Native American/Alaska Native Asian Native Hawaiian/Pacific Islander Black White Unknown MEDICARE PART B RECIPIENTS ONLY I authorize PHC Pharmacy to release information and request payment. I certify that the information given by me in applying for payment under Medicare 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 to Part B Specialists as my Medicare Part B provider. MEDICARE PART B? (Y/N)	LA	ST NAME	FIRST NAME	MI	GENDER AT I	BIRTH (M/F)	DATE OF BIF	RTH				
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MIS-A), immune-mediated syndrome defined by thrombosis and thrombocytopenia such as heparin-	14.		· · · · · · · · · · · · · · · · · · ·		•			□Yes	□No			
	15.											
induced thrombocytopenia, thrombosis with thrombocytopenia? If yes, please circle.				•		• •	n as heparin-	□Yes	□No			
		induced thrombocy	topenia, thrombosi	s with thrombo	cytopenia? If yes	, please circle .						

(CONTINUE ON BACK)

IMMUNIZATION SCREENING AND CONSENT FORM



PATIENT CONSENT

- I have been provided and have read the information sheet about the vaccination(s) I am receiving today.
- I have had an opportunity to review my answers to the questions above and ask questions that were answered to my satisfaction with the Family Health Care (FHC) Pharmacy's pharmacist.
- The information that I provided above is correct and true to the best of my knowledge.
- I agree to wait in the vaccination area for at least 15 minutes for observation by FHC Pharmacy's pharmacist.
- I certify that I am at least 18 years old or am the legal guardian and hereby give my consent to the staff of FHC Pharmacy to administer the vaccine(s) listed below.
- I understand that it is not possible to predict all possible side effects or complications associated with vaccines.
- I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assignees hereby agree to release, indemnify, and hold harmless FHC Pharmacy, its affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed below.
- I agree that FHC Pharmacy will notify my physician of vaccines received by entering vaccine information into the state immunization registry and/or providing documentation as required by state law and/or Board of Pharmacy rules and regulations.
- I understand that FHC Pharmacy can only bill certain insurances and that FHC Pharmacy will provide me with this receipt that can be submitted to my insurance company for possible reimbursement.
- It is my responsibility to work with my insurance company to resolve any issues with payment.

PATIENT/LEGAL GUARDIAN SIGNATURE:													
PATIENT NAME (PRINTED):													
ADMINISTRATION RECORD: PHARMACY USE ONLY													
VACCINE:	SITE OF INJ:	VACCINE:	SITE OF INJ:	VACCINE:	SITE OF INJ:								
LOT:	EXP. DATE:	LOT:	EXP. DATE:	LOT:	EXP. DATE:								
RT OF ADMIN:	MFR:	RT OF ADMIN:	MFR:	RT OF ADMIN:	MFR:								
VIS VERSION:	DOSAGE:	VIS VERSION:	DOSAGE:	VIS VERSION:	DOSAGE:								
DATE OF VACCINA DATE VIS GIVEN	TION/ IMMU	NIZER/PHARMACIST	SIGNATURE	IMMUNIZER NAME (PRINTED)									

PLACE PHARMACY LABEL(S) / BACKTAG(S) HERE

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