ROCKHILL PHARMACY
LONG TERM CARE SERVICES
4240 SW Trafficway, Kansas City, MO 64111
Phone: (816) 799-0123 Fax: (816) 931-0282

Record and Consent for Seasonal Influenza Virus Vaccine

Last Updated: 8/2019

FACILITY/AGENCY__________ RECIPIENT IS EMPLOYEE OF FAC/AGENCY ☐

Last Name ______________________________ First Name ________________________ Birthdate ________

Address ____

Phone ________________________________ Medicare or Medicaid # ______________________________

Name of Family Physician to Report (IMPORTANT) ____

Address ______________________________________ Phone ________________ Fax __________________

Check requested vaccine: ■ Influenza

1. Is this your first time receiving the seasonal influenza vaccine?....................... YES............ NO
2. Are you allergic to eggs or egg products?.. YES............ NO
3. Do you have a fever or are you feeling ill today?... YES............ NO
4. Have you ever had an adverse reaction to a vaccine in the past?.................... YES............ NO
5. Are you 65 years of age or older OR do you smoke OR have a chronic condition (such as asthma or diabetes)?.. YES............ NO
   IF YES: Have you ever had a pneumococcal (pneumonia) vaccination?.......... YES............ NO
6. Are you pregnant or think you may be pregnant?.. YES............ NO
7. Have you been told you have had Guillainn-Barre syndrome?......................... YES............ NO
8. Are you allergic to thimerosal (a mercury-based preservative)?....................... YES............ NO

PATIENT CONSENT

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent of legal guardian of the minor Patient who is at least 9 years of age or older as required by state law; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the pharmacist of Rockhill Pharmacy 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 vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements 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 pharmacist**. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Rockhill Pharmacy, its 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 Rockhill Pharmacy to release any medical or other information to my health care professionals, Medicare, Medicaid or other third party payor necessary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Rockhill Pharmacy with respect to the vaccine(s) listed above.

Missouri Patient Immunization Reporting Notification: This notification is being provided pursuant to §338.010.13 RSMo. By signing below, I understand and acknowledge the administration of this vaccine will be entered into the ShowMeVax system administered by the MO Department of Health & Senior Services unless I opt out here: ☐ **Do NOT report my vaccine information to ShowMeVax**

Signature of Person to Receive Vaccination or Authorized Person

X____ Date______________

THIS SECTION IS FOR OFFICE USE ONLY

Immunizer Name:		Immunizer Signature:		Date:	

VACCINE	DOSE	MANUFACTURER	EXPIRATION DATE	LOT #	INJECTION SITE (IM)	DATE FAXED	INITIALS	VIS DATE	VIS DATE GIVEN
FLULAVAL QUAD 2019-20	0.5ML	ID BIOMEDICAL-GSK			LD RD			8/15/2019	