ingles PHARMACY

Patients: Complete this section if you have a Primary Care Physician (PCP). **PCPs**: Please see vaccine(s) given today.

PCP name:_____ **Fax #**_____

First Name	MI	Last Name	Phone #	Date of Birth	Age

Home Address	City	State	ZIP Code	Medicare Part B Number (if applicable)

Vaccinations - Please check the vaccines you are interested in receiving today.

☐ **Shingles** (50+) ☐ **Pneumonia** (65+, <65 w/ medical conditions) ☐ **Meningococcal** (19+ w/ medical conditions) ☐ **Flu** (13+)
☐ **Other vaccine(s)** (prescription required):

Eligibility Questions - Please answer the following questions.	Y	N
1. Are you sick today?		
2. Do you have allergies to medications, food, yeast, eggs, thimerosal, any other vaccine component or latex?		
3. Have you ever had a serious reaction after receiving a vaccination?		
4. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?		
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease? If yes, please describe:		
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?		
7. Have you had a seizure or a brain or other nervous system problem or Guillian Barré?		
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
9. For women, are you pregnant or is there a chance you could become pregnant during the next month?		
10. Have you received any vaccinations or TB skin test in the past 4 weeks?		
11. Do you have a history of fainting, particularly with vaccines?		
12. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting? *		
13. Have you ever had a shingles or meningitis vaccine?		
14. Have you had pneumococcal vaccine within the last 5 years?		
15. Have you had a physical examination within the last 12 months? If yes, please note the date here:		
16. Are you experiencing any other medical problems today? If so, list the problem and/or symptoms:		

I certify that I am at least 18 years old or the legal guardian of the individual listed above and hereby give my consent to an Ingles Pharmacy Healthcare Provider to administer the requested vaccine(s). I have been offered a Vaccine Information Statement(s) and understand the risks and benefits associated with the vaccines which I have given consent to have administered. I understand that it is not possible to predict all possible side effects or complications associated with vaccines and acknowledge I have had the opportunity to ask questions and that those questions were answered to my satisfaction. I fully acknowledge I have been advised to remain near the vaccination location for 15 minutes for observation by the administering Healthcare Provider. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assigns, hereby agree to release, indemnify, and hold harmless Ingles Markets, Inc, its subsidiaries, divisions, 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 vaccine(s) I have given my consent to receive. I do hereby authorize Ingles Markets to release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate payment or care, to submit a claim to my insurer for the above requested items and services, and to request payment of authorized benefits be made on my behalf to Ingles Markets, Inc, as applicable. I also agree to be fully financially responsible for any cosharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as any items and services I receive 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 Ingles Markets invoices me after the time of service, upon receipt of such invoice.

Patient Signature:_____ Date:_____ RPh:_____

GA Pharmacist use only

Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	Pharmacist's Notes (Pt Med Hx, Chief Complaint, etc):
FluAd	Seqirus	**Flucelvax**	Seqirus					
Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	
	0.5ml		0.5ml					
Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	
	R L		R L		R L		R L	
Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	
Shingrix	GSK	**Prevnar-13**	Pfizer	**Pneumovax-23**	Merck			
Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	
	0.5ml		0.5ml		0.5ml			
Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	
	R L		R L		R L		R L	