

Primary Care Physician: _____

First Name	MI	Last Name	Mother's Maiden Name	Phone #	Date of Birth	Age
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Address	City	State	ZIP Code	Medicare Part B Number (if applicable)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Shingles (50+)
 Pneumonia (65+, <65 w/ medical conditions)
 Tetanus (19+, booster every 10 yrs)
 Hepatitis B (19+ w/ medical conditions)
 Meningococcal (19+ w/ medical conditions)
 Flu (10+, 6+ w/ Rx)

Eligibility Questions - Please answer the following questions.

	Y	N
1. Are you sick today?		
2. Do you have any allergies to medications, foods (e.g. eggs), latex or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list: _____		
3. Have you ever had a serious reaction (including fainting) 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?		
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. Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?*		
11. Have you received any vaccinations in the past 4 weeks? (Answer NOT required for inactivated influenza vaccination.)		
12. For Tdap and adult Td ONLY: Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?*		

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 cost sharing 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: _____

NC Pharmacist use only ----- *No vaccine may be given if the answer is 'yes' to these questions

Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr
FluAd	Seqirus	Flucelvax	Seqirus	Afluria	Seqirus				
Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage
	0.5ml		0.5ml		0.5ml		0.5ml		
Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one
	R L		R L		R L		R L		R L
Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	Vaccine	Mfr	Vaccine	Exp. Date
Shingrix	GSK	Pevnar-13	Pfizer	Pneumovax-23	Merck	Boostrix (Tdap)	GSK		
Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage	Exp Date	Dosage
	0.5ml		0.5ml		0.5ml		0.5ml		
Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one	Lot	Arm - circle one
	R L		R L		R L		R L		R L