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) ☐ **Tetanus** (19+, booster every 10 yrs) ☐ **Flu** (12+)
☐ **Hepatitis B** (19+ w/ medical conditions) ☐ **Meningococcal** (19+ w/ medical conditions) ☐ Other:_____

| Eligibility Questions - Please answer the following questions. | Y | N |
|---|---|---|
| 1. Are you sick today? If 'yes', please answer 'a' thru 'd' below. If 'no', skip to question #2. | | |
| a. Do you have a new fever? | | |
| b. Do you have a cough? | | |
| c. Do you have diarrhea? | | |
| d. Have you been vomiting? | | |
| 2. Have you ever fainted or felt dizzy after receiving a vaccine? | | |
| 3. Have you ever had a reaction after receiving a vaccination? | | |
| 4. Do you have a long-term health problem with heart or lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder? | | |
| 5. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs? | | |
| 6. Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) | | |
| 7. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems? | | |
| **For Live Vaccines Only:** | | |
| 8. Are you currently on home infusions, weekly injections (such as adalimumab, infliximab and etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments? | | |
| 9. Have you received any vaccinations or skin tests in the past four weeks? | | |
| 10. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year? | | |
| 11. Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks? | | |

**Consent**

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well. Please review the statement below confirming your consent for vaccination and provide the information requested:

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:_____

SC Pharmacist use only

| Vaccine | Mfr | Vaccine | Mfr | Vaccine | Mfr | Vaccine | Mfr | Vaccine | Mfr |
|---|---|---|---|---|---|---|---|---|---|
| **FluAd** | Seqirus | **Flucelvax** | Seqirus | **Fluarix** | GSK | | | | |
| Exp Date | Dosage | 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 | Lot | Arm - circle one |
| | R L | | R L | | R L | | R L | | R L |
| VIS Date: | | VIS Date: | | VIS Date: | | VIS Date: | | VIS Date: | |
| Vaccine | Mfr | Vaccine | Mfr | Vaccine | Mfr | Vaccine | Mfr | Vaccine | Exp. Date |
| **Shingrix** | GSK | **Prevnar-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 |
| VIS Date: | | VIS Date: | | VIS Date: | | VIS Date: | | VIS Date: | |