



Store # _____ Address _____

RX # _____ City, State, Zip _____ Telephone _____

Inactive Vaccine Consent and Administration Record**Patient Information:**

Last Name _____ First Name _____ Date of Birth _____
 Address _____ City, State, Zip _____ Phone _____
 Primary Care Provider (PCP) Name _____ PCP Phone # _____
 PCP Address _____ City, State, Zip _____ PCP Fax # _____

Screening Questions:

	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever or acute illness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. For women: Are you pregnant or nursing? Could you become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read or have had explained to me the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize CVS Pharmacy® ("CVS®") to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid 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.

DISCLOSURE OF RECORDS: I understand that CVS® may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at CVS (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that CVS will use and disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy).

X _____ Date: _____
Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Vaccine Administration Information:

Administration Date _____ Vaccine _____ Manufacturer _____
 Lot # _____ Exp. Date _____ Route _____ Site _____
 Volume (mL) _____ VIS Version Date _____ Date VIS Given to Pt _____

 Administering Immunizer Name & Title _____ Administering Immunizer Signature _____

PATIENT INSURANCE INFORMATION:
Primary:
 Plan Name: _____ BIN#: _____
 Name: _____ Condor: _____
 ID#: _____ Group: _____

Affix Rx Label Here

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636 (1-800-CDC-INFO)** or
 - Visit CDC's www.cdc.gov/flu

Vaccine Information Statement (Interim)
**Inactivated Influenza
Vaccine**



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