Lihue Pharmacy Consent and Release – Influenza Vaccinations

____ ____/____/____ ______ ☐F ☐M

PRINT LEGAL Last Name of Patient First Middle Birth Date Age

____ (______)__________________

PHYSICAL Address City State ZIP Cell or /Home Phone

____ ____

Primary Insurance Ins ID# Primary Care Physician Phone #

____

Secondary Insurance Ins ID#

If you are not the primary subscriber, please provide Subscriber's Name, DOB and Gender:

____

LAST NAME FIRST RELATION DOB GENDER

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Lihue Pharmacy, LLC., on behalf of its pharmacy operations in all divisions, (Lihue Pharmacy) has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Lihue Pharmacy, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Lihue Pharmacy permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Lihue Pharmacy to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Lihue Pharmacy and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above described vaccine(s) as provided by the manufacturer and any negligence of Lihue Pharmacy in connection with the related Injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

X____ ______________________________

Signature of Person to Receive Vaccine(s) Date of Immunization

	Please answer these questions by checking the boxes. If the question is not clear, please ask the vaccinator.	YES	NO	DON'T KNOW
1	Are you sick today or experiencing a high fever (over 100 degrees F)?			
2	Do you have a serious allergy to ANY medications or food? (Example: Eggs, Gelatin, Thimerosal, Neomycin,Gentamicin) If yes, please list: ______________________			
3	Have you ever had a serious reaction or fainted after receiving any vaccination?			
4	Do you have sensitivity to latex? (Example: gloves or bandages)			
5	**FOR WOMEN:** Are you pregnant or are you considering becoming pregnant?			
6	Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			

--BELOW LINE PHARMACY USE ONLY--

☐ Check box to confirm patient identity verified ☐ Check box to confirm vaccine/drug to be administered verified

Vaccine	Lot # of Vaccine	Exp. Date	Manufacturer	Dosage	Site of Injection	Time	VIS Date
FLUZONE PFS 90686			SANOFI	0.5 ML	IM L / R DELTOID	AM / PM	08/15/19
FLUZONE HIGH DOSE 65+ PFS 90662			SANOFI	0.5 ML	IM L R DELTOID	AM / PM	08/15/19
FLUAD IIV4 65+ PFS 90694			SEQURIS	0.5 ML	IM L R DELTOID	AM / PM	08/15/19
FLULAVAL PFS 90686			GSK	0.5 ML	IM L / R DELTOID	AM / PM	08/15/19
AFLURIA PFS 90686			SEQIRUS	0.5 ML	IM L / R DELTOID	AM / PM	08/15/19
AFLURIA MDV 90688			SEQIRUS	0.5 ML	IM L R DELTOID	AM / PM	08/15/19
				0.5 ML	IM L R DELTOID	AM / PM	08/15/19

Printed Name of Vaccinator:______________________________________**RPh / LPN / RN /** **VIS provided to patient dated: 8/15/2019**

LIHUE PHARMACY GROUP

Lihue Pharmacy	**Lihue Professional Pharmacy**	**Lihue Clinic Pharmacy**
4491-A Kolopa St.	3-3420 B Kuhio Hwy Ste 101	3216 Elua St.
Lihue HI 96766	Lihue HI 96766	Lihue HI 96766
808 246-9100		

Business Office: 4490 Kolopa Street, Ste. B, Lihue, HI 96766

Name of Patient (Print)

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received or have been offered but declined a copy of Lihue Pharmacy Group's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Lihue Pharmacy Group health care operations. The Notice of Privacy Practices also describes my rights and Lihue Pharmacy Group's duties with respect to my protected health information. The Notice of Privacy Practices is posted online and at the customer service counter of Lihue Pharmacy Group.

Lihue Pharmacy Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I understand that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient ____ Date __________________

OR

Signature of Person Authorized by Law, or designated caregiver

____ Date ___________________________

If this form is not signed by the patient, please **explain** below.

- ☐ See BENEFICIARY INFORMATION sheet
- ☐ Patient not available or unable to sign
- ☐ Other (specify) ______________________