Seasonal Flu (Influenza) vaccine

Gateway Pharmacy

_____ ____ _____
(First Name) (MI) (Last Name)

Street _____

City _____State_____Zip_____

Phone(____)_____ Male ☐ Female ☐

Birth date _____ (mm/dd/yy) Age_____
Month Date Year

State where you were born_____

Country where you were born if not USA _____

Gateway Pharmacy Staff:

Please place Rx label here.

Allergies:_____

Physician:_____ Cardholder_____(husband) (wife) (mother) (father) (guardian)

Primary Insurance_____ ID#_____

Cardholder's Birth date_____ RxBIN: _____ RxPCN: _____ RxGRP: _____

The following questions will help us determine which vaccines may be given to you today. Please check the appropriate answer. If any question is not clear, please ask us to explain it.

	Yes	No	Don't know
1. Are you sick today or do you currently have a fever or infection?			
2. Do you have allergies to medications, eggs, thimerosal, neomycin, gelatin, vaccine, or any vaccine component?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Do you, any person who lives with, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem?			
5. Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, other steroids, anticancer drugs, immunosuppressant drugs or X-ray treatment?			
6. During the past year have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?			
7. If you or you child are under the age of 18, are you taking aspirin or medicines containing aspirin?			
8. For women: Is it possible that you are pregnant or may become pregnant in the next 3 months?			
9. Have you had any other immunizations or injections in the last 2 months?			

I certify that I am at least 18 years old and hereby give my consent to the staff of Gateway Pharmacy to administer the vaccine(s) listed below. I have read, or have had read to me, the information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assigns hereby agree to release, indemnify and hold harmless Gateway Pharmacy, LLC., its agents, offices, 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 vaccines listed below. **This immunization will be entered into the statewide immunization registry. You may opt out of that system if you choose. If you want to opt out of immunization reporting, please let the pharmacy staff know.** ☐ **I do not want my immunizations reported to the State Immunization System.**

*** Standard Dose vaccine will be given routinely; High Dose may be available upon request ***

I agree to wait near the vaccination location approximately 20 minutes for observation by a pharmacist.
I authorize payment to go directly to the provider of service (Gateway Pharmacy) whose bills are attached to this form.

Signature_____ Date: _____

For office use only:

(X)	Vaccine name / mfg:	Lot#/Exp Date	Dose:	Administration Route: (Please Circle R or L)	Administered by: (staff Initials)
	Fluzone / Sanofi		0.5ML	IM R / L	
	Fluzone HD / Sanofi		0.7ML	IM R / L	
	Afluria / Seqirus		0.5ML	IM R / L	
	FluMist / AstraZeneca		0.2ML	INL (0.1ML per nostril)	

☐Flu Inactive or Intranasal VIS 8/6/21

(R.09/17/2021)