



Store # #06415 Address 1154 LIBERTY PIKE

RX # \_\_\_\_\_ City, State, Zip FRANKLIN, TN 37067 Telephone (615) 791-1164

**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 &amp; Title \_\_\_\_\_

Administering Immunizer Signature \_\_\_\_\_

**INSURANCE INFORMATION:**  
 Please attach a front and back copy  
 of your health insurance ID card.

*Affix Rx Label Here*