Insurance Information

BIN# _____

PCN#_____

GROUP _____

ID#_____

CARE-MART PHARMACY
OFF-SITE IMMUNIZATION

****** PLEASE PRINT CLEARLY******

NAME _____

LAST FIRST MI (Jr, Sr, I, II,III) as it appears on card

Date of Birth _____/ _____/ _____ Male/Female _____

****** PLEASE WRITE YOUR ADDRESS THAT IS ASSOCIATED WITH INSURANCE CARD******

Address: _____

City:_____ Zip Code_____ Phone:_____

****** PLEASE WRITE YOUR DOCTOR'S INFORMATION, IF KNOWN******

Primary Care Physician Name _____ Phone:_____

Statement: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the part who accepts assignment

Vaccine Receiving Today : **Inactived Influenza Vaccine (IIV)** ***Circle your answer***

1.	Are you sick today?	Yes	No
2.	Do you have allergies to medications, food, a vaccine component or latex?		
	• If yes, please list allergies _____	Yes	No
3.	Have you had a serious reaction after receiving a vaccination?	Yes	No
4.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
5.	Have you had a seizure or a brain or other nervous system problems?	Yes	No
6.	Have you had mastectomy, lymphedema, or lymph nodes removed?	Yes	No

I have read or had explained to me the information on this form and Vaccine Information Statements (VIS) about flu. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risk for the flu vaccine and ask that it be given to me or the person named below for whom I am authorized to make this request. I understand it is recommended to remain on site for 15 minutes following injection.

Signature: _____ Date: _____/ _____/ _____

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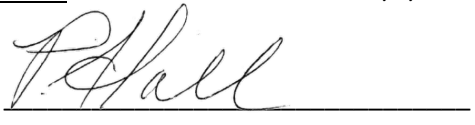
To be used by Pharmacy Department Only:

Vaccine Name: Afluria Influenza Vaccine Quad 2024-2025 Manufacturer: Seqirus Lot: P100710088

Injection Site: RIGHT / LEFT DELTOID (IM) Amount: 0.5 mL VIS Date: 8/6/21

Pharmacist Name: Preston Hall Yaneya Hall Signature: 

Insurance Information

BIN# _____

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CARE-MART PHARMACY
OFF-SITE IMMUNIZATION

****** PLEASE PRINT CLEARLY******

NAME
(Nombre)_____
LAST (Apellido) ***FIRST (Nombre)*** MI (Jr, Sr, I, II,III) as it appears on card

Circule su respuesta

Date of Birth ***(Fecha de Nacimiento)*** _____/ _____/ _____ ***Male (Hombre)*** / ***Female (Mujer)***

****** PLEASE WRITE YOUR ADDRESS THAT IS ASSOCIATED WITH INSURANCE CARD******

Address (Dirección):_____

City (Ciudad):_____ Zip Code (Código postal)_____

Phone ***(Número de teléfono)***:_____

****** PLEASE WRITE YOUR DOCTOR'S INFORMATION, IF KNOWN******

(El nombre del doctor) ***(Número de teléfono)***

Primary Care Physician Name _____ Phone:_____

Declaración: Autorizo la divulgación de cualquier información médica o de otro tipo necesaria para procesar el reclamo.

Vacuna que recibe hoy: **Inactived Influenza Vaccine (IIV)** ***Circule su respuesta***

1.	¿Está enfermo hoy?	Sí	No
2.	¿Tiene alergias a medicamentos, alimentos, algún componente de la vacuna o al látex?		
	• En caso afirmativo, indique las alergias. _____	Sí	No
3.	¿Ha tenido una reacción seria después de recibir una vacuna?	Sí	No
4.	¿Toma cortisona, prednisona, otros esteroides o medicamentos contra el cancer, o ha recibido tratamientos de radiación?	Sí	No
5.	¿Ha tenido convulsiones o problemas cerebrales u otros problemas del sistema nervioso?	Sí	No
6.	¿Ha tenido una mastectomía, linfedema o extirpación de ganglios linfáticos?	Sí	No

He leído o me han explicado la información de este formulario y las Declaraciones de información sobre vacunas (VIS) sobre la gripe. Tuve la oportunidad de hacer preguntas que fueron respondidas satisfactoriamente. Creo que entiendo los beneficios y riesgos de la vacuna contra la gripe y solicito que me la administren a mí o a la persona nombrada a continuación para quien estoy autorizado a realizar esta solicitud. Entiendo que se recomienda permanecer en el lugar durante 15 minutos después de la inyección.

Signature ***(Firma)***: _____Date ***(Fecha):*** _____/ _____/ _____

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To be used by Pharmacy Department Only:

Vaccine Name: Afluria Influenza Vaccine Quad 2024-2025 Manufacturer: Seqirus Lot: P100710088

Injection Site: RIGHT / LEFT DELTOID (IM) Amount: 0.5 mL VIS Date: 08/06/21

Pharmacist Name: Preston Hall Yaneya Hall Signature: