Caldwell
Pharmacy~Home Medical Equipment~Gifts
(870) 238-7085 M-F 8:30-6; Sat. 8:30-12
www.caldwellmax.com

Pharmacist Immunization Program
Improving Arkansas wellness.

Name: _____ Date of Birth: _____ Age: _____

Gender (circle one): Male / Female SSN: _____

Race: _____ Ethnicity (circle one): Hispanic or Latino/Non-Hispanic or Latino

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone#: _____ Family Doctor: _____

Method of payments: Cash / Medicare / Private Insurance (please provide card to pharmacy)

Insurance Cardholder Name: _____ Cardholder Date of Birth: _____

	YES	NO	DON'T KNOW
1. Are you feeling sick today or have a fever?			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Have you ever had Guillain-Barré syndrome?			
5. <18 years old: Have you had a well-child visit with your pediatrician in the last 12 months?			

Consent and waiver: All of the information I have provided is correct. I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the standing order physician and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy's privacy policies according to HIPAA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry and allow the registry to share with other providers. I am aware that an immunization certified student pharmacist or technician might be administering this medication. **I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Vaccine: ☐ INFLUENZA ☐ INFLUENZA HIGH-DOSE (only 65yo and older)

Signature of patient or guardian: _____

For Pharmacy Use Only:

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	BRAND NAME (MFR)	LOT #	EXP DATE
Influenza	0.5mL	RT LT	DELTOID	IM	8/6/21	Flucelvax (Seqirus)		
Influenza HD	0.5mL	RT LT	DELTOID	IM	8/6/21	Fluad (Seqirus)		

Signature and Title of Vaccine Administrator _____Date _____