BUTT DRUGS
Since 1952

Flu/Pneumococcal Vaccination Consent Form

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First Name:	Middle Initial:	Last Name:	
Home Address:	City:	State:	Zip:
Phone:	Date of Birth:	Age:	Gender:
Primary Care Physician:	Physician City:		Physician Phone:
Vaccine Requested: ☐ Influenza ☐ Pneumococcal			

The following questions will help us determine your eligibility to be vaccinated today.	Yes	No	Don't Know
1. Do you have fever, diarrhea, or have you vomited today?			
2. Do you have allergies to medications, food, or any vaccine? (Examples: Eggs, Gelatin, Gentamycin, Streptomycin, Neomycin, Thimerosal, Baker's Yeast)			
3. Have you ever had a serious reaction after receiving any vaccination?			
4. Have you ever had a seizure disorder, a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system disorder?			
5. Have you ever had a pneumococcal or "Pneumonia" vaccination?			
7. Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe:			
8. **For women:** Are you pregnant or considering becoming pregnant in the next month?			

Influenza/Pneumococcal Consent

I have read, or have had explained to me, the Vaccine Information Statement about ***influenza/pneumococcal*** *vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the* ***influenza/pneumococcal*** *vaccination be given to me (or the person named above for whom I am authorized to make this request). On behalf of myself, my heirs, and my personal representative, I hereby release and hold harmless Butt Drugs, Inc. its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed. I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.*

Customer Signature: Date:

Immunizer Name:			Immunizer Signature:			
Injection Site:			Immunization Date & Date Recipient Given VIS:			
Vaccine:	**Lot:**	**Exp. Date:**	**Manufacturer:**	**Dosage:**	**Route:**	**VIS Date:**