BUTT DRUGS
Since 1952

Shingles Vaccination Consent Form

115 East Chestnut Street—Corydon, Indiana 47112
*P:*812-738-3272 *W:*ButtDrugs.com *F:*812-738-1406

First Name:	Middle Initial:	Last Name:	
Home Address:	City:	State:	Zip:
Phone:	Date of Birth:	Age:	Gender:
Primary Care Physician:	Physician City:		Physician Phone:
Medicare B Number (if any):	Allergies:	Vaccine Requested:	
Insurance Carrier (if any):	Group Number:	PCN:	

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. **If you are 65 years of age or older:** Have you ever had a pneumococcal or "Pneumonia" vaccination?			
6. **For women:** Are you pregnant or considering becoming pregnant in the next month?			
7. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system problem?			
8. Are you currently on home infusions, weekly injections and/or taking medications such as Remicade, Enbrel,			
9. Do you take cortisone, prednisone, other steroids, anticancer drugs or have had x-ray treatments?			
10. Have you received a transfusion of blood or blood products, or been given a medicine called immune			
11. Have you received any vaccinations in the past 4 weeks?			

I certify that I am: (i) the patient and at least 18 years of age. Further I hereby give my consent to the pharmacist of Butt Drugs, Inc. to administer the vaccine I am requesting. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines. I understand the risks and benefits associated with the above vaccine and have received, read, and/or had explained to me the Vaccine Information Statement on the vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after the administration for observation by the administering pharmacist. 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, contactors, 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 Butt Drugs, Inc. to release any medical or other information to my health care professionals, Medicare, Medicaid, or other third party payor necessary to effectuate care payment and request that payment of authorized benefits to be made on my behalf to Butt Drugs, Inc. with respect to the vaccine listed. Butt Drugs, Inc. will report all vaccinations to any applicable state immunization registries unless I inform the pharmacist that I wish to opt out of such reporting.

Customer Signature: Date:

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