Shern Drug Inc.
Cecil's Pharmacy
300 E Main St
Lehi, UT 84043-2242
801-768-4244

INFLUENZA/H1N1 IMMUNIZATION FORM

Last Name: First: Date of Birth:

Address: City: State: Zip Code:

Phone number:

Please answer all questions: Yes No

	Question	Yes	No
1.	Are you currently ill or have a fever?	[ ]	[ ]
2.	Have you or a household member been diagnosed with COVID-19 in the past 14 days?	[ ]	[ ]
3.	Do you have a known or suspected pregnancy................................	[ ]	[ ]
4.	Have you received any vaccinations in the last 28 days?	[ ]	[ ]
5.	Do you have or ever had Guillain-Barré Syndrome?	[ ]	[ ]
6.	Do you have any allergies to any vaccine components? (e.g. bovine protein, phenol or thimerosal)	[ ]	[ ]
7.	Have you ever had the influenza vaccine before?	[ ]	[ ]
8.	Have you ever had a serious reaction the influenza vaccine?	[ ]	[ ]

I have read or have had explained to me, the Vaccine Information Statement (VIS) about Influenza Vaccines. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of receiving the influenza vaccine and request that the vaccine be given to me, or to the person named for who I am authorized to make this request. I understand that if I experience side effects, I am responsible for following up with my physician at my expense. I hereby release the pharmacy that is administering the vaccine; the subsidiaries and affiliates of the pharmacy; the employees and agents of the pharmacy, and the owner of the pharmacy from any and all liability that might arise from this vaccination.

I acknowledge receiving the pharmacy's Notice of HIPPA privacy practices.

I wish to have Shern Drug Inc. bill my insurance for the vaccination given. I authorize the release of any medical or other information necessary to process this claim. I request that payment of my insurance benefits be paid directly to Shern Drug Inc. If for any reason my insurance refuses payment to Shern Drug Inc., I realize that I will be liable for the full amount due to Shern Drug Inc. and any expense Shern Drug Inc. may incur in collecting this debt.

X

Signature of person to receive vaccine or authorized to make the request **Date**

**********************************FOR PHARMACY USE ONLY**************************************

[X] INFLUENZA VACCININATION

MANUFACTURER NAME: ___GSK_______ **LOT NUMBER:** ___5X5J2___ **NDC#: __19515-0816-52__**

EXPIRATION DATE: __06/30/2021___ **SITE OF INJECTION: [ ] LEFT DELTOID [ ] RIGHT DELTOID**

SIGNATURE OF PERSON GIVING INJECTION **DATE VACCINATED**