Randol Mill Pharmacy
1014 N. Fielder Rd. Arlington, TX 76012
817-274-1883

Vaccine Administration Consent Form

I agree that the person named below will receive the vaccine indicated and that this person will have a vaccine administered by injection to prevent infectious disease. I received a current copy of the Vaccine Information Statement for this vaccine and have had the opportunity to ask questions concerning the benefits and risk of the vaccine and the diseases they prevent. I freely and voluntarily authorize the administration of the vaccines to me or the person named below for whom I am authorized to make this decision.

Please Answer the Following Questions:

_____ Yes _____ No Are you sick today?

_____ Yes _____ No Do you have any allergies to eggs, gelatin, other food, medications or vaccines?

_____ Yes _____ No Have you had any serious reactions from a vaccine?

_____ Yes _____ No Do you have a seizure or brain disorder or nervous systems problems?

Information about the person to receive the vaccine:

Date: ____/_____/_____ Telephone: (_____)_____

Name: _____ Date of Birth: _____/_____/_____

Street Address: _____ City: _____ State: _____ Zip: _____

X _____ _____ _____
Signature of Patient or Parent/ Legal Guardian (If patient is under 18) Doctor's Name Doctor's Fax

I authorize the release of any medical or other information necessary to process the claim. I also request payment from the government to the party who accepts assignment. I acknowledge that I have received a copy of the RMP Notice of Privacy Practices and that RMP may bill my health benefit plan on my behalf. I also acknowledge I am financially responsible for fees not paid by my health plan.

Vaccine, Brand Name	Qty	MANUF.	Route	Lot Number/ Exp. Date	Site of Administration
Influenza Afluria Quad©	0.5 ml	Seqirus	IM		LT. Deltoid RT. Deltoid
Influenza Flucelvax Quad©	0.5 ml	Seqirus	IM		LT. Deltoid RT. Deltoid
Influenza Fluad Quad HD©	0.5 ml	Seqirus	IM		LT. Deltoid RT. Deltoid
Influenza Fluzone Quad HD©	0.5 ml	Sanofi	IM		LT. Deltoid RT. Deltoid
Pneumococcal Prevnar 20©	0.5 ml	Pfizer	IM		LT. Deltoid RT. Deltoid
TDAP Boostrix©	0.5 ml	Sanofi	IM		LT. Deltoid RT. Deltoid
Herpes Zoster Shingrix©	0.5 ml	GSK	IM		LT. Deltoid RT. Deltoid
Other					

Billing Information:	VIS Given:	
Cash: _____ TP Name: _____	Yes ☐ No ☐	X _____ Immunizer Signature