HEMMINGSEN since 1936 Rexall DRUGSTORE

RSV VACCINE CONSENT FORM

Last Name _____ First Name _____ Sex: □ Male □ Female

Address _____ City _____ State _____ Zip _____

Date of Birth _____Phone # _____ Physician _____

Not all individuals requesting the Respiratory Syncytial Virus (RSV) vaccine can safely be immunized against RSV. Consult with your physician to obtain RSV vaccine if one or more of the following is true:

1. Have you ever had a severe reaction to any previous vaccine? □ Yes □ No
2. Are you Allergic to Latex? □ Yes □ No
3. Do you have a fever or active illness? □ Yes □ No
4. Are you pregnant? □ Yes □ No
   If YES # of weeks_____
5. Do you have a past history of Guillain-Barre Syndrome? □ Yes □ No
6. Are you under the age of sixty (60)? □ Yes □ No
7. Are you currently receiving blood thinners such as coumadin, aspirin or heparin? □ Yes □ No

Having received an explanation and informed consent, I hereby agree to release and hold Hemmingsen Drug Store, its employees, agents and representatives harmless from further responsibility with regard to my receiving the injections.

As with any medication, there are risks and possible side effects/reactions. Side effects of RSV vaccine are generally mild in adults and occur within 6-12 hours after vaccination and can persist for one or two days. These reactions consist of soreness of the injection site, headache, muscular aches,nausea and in rare cases, even death. If you should have a reaction, you should CONTACT YOUR PHYSICIAN, and Hemmingsen Drug Store pharmacist (269) 781-3411.

I have received and read the MI/CDC (VIS) RSV Vaccine Information Statement, as well as the above information, and have had the opportunity to ask questions [please initial ____]. I understand the benefits and risks of the RSV vaccine as described. I request the RSV vaccine to be administered to me or to the person named for whom I am authorized to sign.

_____ _____

Signature: Patient or Authorized Representative Date

I request that this provider be paid authorized Medicare/Medicaid/Private Insurance benefits on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. **I understand that I am responsible for the charges if my Medicare/Medicaid/Private Insurance coverage is not appropriate.**

Patient or Authorized Rep Signature _____ __Payment to Patient √ **Payment to Provider**

Vaccine product & Lot # _____ Expiration Date _____

Sight of injection: □ Right Deltoid □ Left Deltoid Clinic:Hemmingsen Drug Store

Administrator Signature and Date _____