Froedtert & Medical College of Wisconsin

- ☐ Froedtert Pharmacy #025 — 9200 W. Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #050 — 9200 W. Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #075 — 9200 W Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #100 — 3200 Pleasant Valley Rd West Bend, WI 53095
- ☐ Froedtert Pharmacy #125 — W180 N8085 Town Hall Rd. Menomonee Falls, WI 53051
- ☐ Froedtert Pharmacy #150 — W180 N8000 Town Hall Rd Menomonee Falls, WI 53051
- ☐ Froedtert Pharmacy #175 — 1155 N. Mayfair Rd. Wauwatosa, WI 53226
- ☐ Froedtert Pharmacy #200 — 925 N. 87th St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #225 — 9200 W. Wisconsin St. Milwaukee, WI 53226
- ☐ Froedtert Pharmacy #250 — 4805 S. Moorland Rd. New Berlin, WI 53151
- ☐ Froedtert Pharmacy #325 — 7901 S. 6th St. Oak Creek, WI 53124
- ☐ Froedtert Pharmacy #350 — 1700 W Paradise Drive West Bend, WI 53095
- ☐ Froedtert Pharmacy #375 — 1650 S 41st St Manitowoc, WI 5422
- ☐ Froedtert Pharmacy #400 — 10000 W Bluemound Rd Wauwatosa, WI 53226

Flu Vaccine Consent Form

Name:			**Date of Birth:**	**Age:**
Address:			**Allergies:**	
City:	**State:**	**Zip:**	**Phone:**	

	Insurance Information		
	MEDICARE ID: *(Red/White/Blue Card, if available)*		
	OTHER INSURANCE INFO: *(Medicare Part D/Advantage, Commercial insurance, etc.)*	**Rx BIN**	
		PCN	
		Rx ID	
		Rx Group	
		☐ **Cardholder**	☐ **Spouse**
		☐ **Child**	☐ **Other**

	Screening Questions	**Yes**	**No**	**Don't Know**
1	Are you sick today?			
2	Do you have allergies to any potential influenza vaccine components? (Examples: eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein)? If YES, please specify:			
3	Have you ever had a serious reaction after receiving a vaccine?			

I have received, read, and understand the Vaccine Information Statement provided by Froedtert and the Medical College of Wisconsin. I have had an opportunity to ask questions about the vaccine, and my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccination, the alternative modes or treatment, and I expressly consent, request and authorize the administration of the vaccination(s) documented above to me. I agree to stay in the general area for 15 minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. In the event my designated payor does not cover my immunization, I understand I may be financially responsible for the cost of the immunization. I hereby release the entity/organization that owns or leases the place in which I receive the vaccination, its officers, employees, and agents from any and all liability arising from the negligence of Froedtert and the Medical College of Wisconsin, its employees and agents, on behalf of myself, my spouse, my heirs and personal representatives. I hereby release Froedtert and the Medical College of Wisconsin, its officers, employees and agents, from any and all liability arising from this vaccination, except for liability arising from negligence, on behalf of myself, my spouse, my heirs and personal representatives.

_____ _____ _____

Signature of Person to Receive Vaccine | Date | Time

If a patient is a minor or otherwise unable to sign, complete the information below:

_____ _____ _____

Signature of Parent, Legal Guardian, Health Care Agent, or Other Authorized Representative | Date | Time

Relationship to patient: _____

STAFF ONLY BELOW THIS LINE

Vaccine	**Dose**	**Manufacturer & Lot #**	**Expiration Date**	**Injection Site & Route**	**VIS Date**	**Date VIS given to pt**
☐ Fluzone Quad				☐ L ☐ R Deltoid IM	8/6/2021	
☐ Fluzone High Dose				☐ L ☐ R Deltoid IM	8/6/2021	
☐ Fluarix Quad				☐ L ☐ R Deltoid IM	8/6/2021	

Authorizing Pharmacist Name:	**NPI:**		**Documentation:**
			☐ WIR
			☐ Scanned Consent Form

_____ _____ _____

Printed Name & Signature of Immunizing Pharmacist | NPI | Date/Time