125 South Peters Rd, Knoxville, TN, 37923
865-381-2500

Name(First & Last):________________________ **DOB**:_______________
Address: ________________________
____
Phone: ________________________

Please answer the following information:

1. **Are you under the age of 18?**	Yes	No
2. **Do you have a known or suspected pregnancy?**	Yes	No
3. **Are you currently ill or have a fever?**	Yes	No
4. **Are you currently on antibiotics?**	Yes	No
5. **Do you have or ever had Guillain-Barre' Syndrome?**	Yes	No
6. **Do you have an allergy to eggs?**	Yes	No
7. **Have you ever had the influenza vaccine before?**	Yes	No
8. **Have you ever had an allergic reaction to influenza vaccine?**	Yes	No

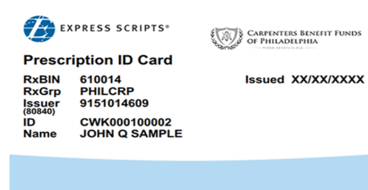
I have read or have had, explained to me, information about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of receiving the influenza vaccine and request that the vaccine be given to me, or to the person named for who I am authorized to make this request.

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

I wish to have Mac's Pharmacy 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 Mac's Pharmacy Inc. If for any reason my insurance refuses payment to Mac's Pharmacy Inc., Mac's Pharmacy Inc. may incur in collecting the debt.

RXBIN: ________________________
RXPCN: ________________________
RXGroup:________________________
Issuer/Member ID:_________________

Example of insurance card:



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

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

[ ] INFLUENZA VACCINE

MANUFACTURER NAME: ____________________________ **LOT NUMBER**: ___________

NDC: ____________________________________ **EXPIRATION**: ____________

SITE OF INJECTION: [ ]LEFT DELTOID [ ] RIGHT DELTOID

____ __________________________
SIGNATURE OF PERSON GIVING INJECTION **DATE:**