65+ FLU / COVID-19 VACCINE CONSENT FORM 2025-2026

NAME First/Last _____**Date of Birth**_____**Age**_____

Address _____**City** _____ **Zip Code**: _____

Phone_____ **Gender** Male Female **Physician/Provider**_____

***if you are 65 to 74 years of age, you may be eligible for the RSV vaccine or if you are 75 years of age or older and have not yet received the RSV vaccine. Ask your pharmacist for more information!*

- **Please check the vaccine(s) you wish to receive today:** ☐ **Flu** ☐ **COVID-19**

MEDICAL QUESTIONS – Please answer each question	YES	NO
1. Do you have allergies to any ingredient included in vaccines? (latex, eggs, polyethylene glycol, polysorbate 80)	☐	☐
2. Have you had a serious reaction to a vaccine/injectable medication in the past?	☐	☐
3. When was your last COVID-19 vaccination? Fall 2024 Spring 2025 Other:_____		
4. Do you have history of any of the following conditions (Check all that apply):	☐	☐
☐ Guillain-Barre Syndrome (a temporary severe muscle weakness) ☐ Myocarditis or pericarditis ☐ Multisystem Inflammatory Syndrome (MIS-C or MIS-A)		
5. Do you have an immunocompromising condition due to any cause?	☐	☐
6. Are you sick today or running a fever?	☐	☐

SIGNATURE AND CONSENT for vaccination(s) as indicated above

I understand the benefits & risks of the influenza(flu) vaccine &/or COVID-19 vaccine and request that vaccines (as indicated above) be administered to me or to the person named below for whom I am authorized to make this request. I acknowledge the QR code (below) provides me with current Vaccine Information Sheet(s) & am aware of any possible side effects. I hereby assume any risks related to receiving the vaccine(s) & release Lewis Drug & its agents, staff, representatives, successors & assigns, & subrogates from any & all liability related, directly or indirectly, which may arise from having been given the indicated vaccine(s). If I have received the vaccine(s) in my vehicle or otherwise outside of the Lewis Drug facility, I acknowledge that Lewis Drug has recommended that I park and wait for 15 minutes after vaccination to ensure I don't evidence any adverse reactions.

_____

Signature of patient or POA (REQUIRED) **Date**

FOR STAFF ONLY: Lewis Drug #_____ **or CLINIC**_____

Vaccine	Date of Administration:	Site of Administration	Immunizer Signature/title:
FLU		**Deltoid:** Left Right	
COVID		**Deltoid:** Left Right	

FLU Manufacturer - Vaccine	Lot Number	Expiration Date	VIS - Scan QR code below
Sanofi – **Flublok TIV** PFS 2025-2026 **age 9+**			1/31/2025
Seqirus – **Fluad TIV** PFS 2025-2026 **age 65+**			
Other:			

COVID-19 Manufacturer - Vaccine	Lot Number	Expiration Date	VIS - Scan QR code below
Moderna – **Spikevax** PFS 2025-2026 **age 12+**			1/31/2025
Moderna - **mNexspike** PFS 2025-2026 **age 12+**			
Novavax – **Nuvaxovid** PFS 2025-2026 **age 12+**			
Pfizer – **Comirnaty** PFS 2025-2026 **age 12+**			