

Signature on File and Medical Release
Statement to Permit Payment of Medicare/Medicaid
Benefits to Provider

GES Pre K - 3
GHS

Recipient Name: _____

Address _____

Phone _____ D.O.B. _____

Insurance ID#: _____

I request that payment of authorized Medicare, Medicaid or insurance benefits be made on my behalf to:

First Health Pharmacy
1300 Sunset Drive • Suite C
Grenada, MS 38901
662.226.0666

Medical Information Release

I authorize any holder of medical or other information about me to release to Medicare or Medicaid, the fiscal agents, or this provider any information needed to determine these benefits or the benefits payable for related services.

This authorization is valid for my lifetime.

Recipient's Signature _____ Date _____

Influenza Questionnaire

1. Have you ever had a reaction to the influenza vaccine? No _____ Yes _____
2. Do you have an allergy to eggs? No _____ Yes _____
3. Are you sick today or do you have fever today? No _____ Yes _____
4. Are you pregnant in the first trimester? No _____ Yes _____

Influenza Vaccine Consent

I have read and understand the influenza vaccine information sheet. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that it be given to me, or to the person named below for whom I am legally authorized to make this request. I, hereby, release First Health Pharmacy and/or the person administering the vaccine to me, from any all liability related to this vaccine.

Name _____ Signature _____

(Place pharmacy label here)

Injection location=Deltoid L ___ R ___ Signature of person giving injection _____