Please Fill out both Sides

2131 E 32nd St
Joplin, MO 64804
Phone: 417-781-2332
Fax: 417-659-8344

Flu Shot Billing Information

Please provide information off of the patient's PHARMACY card not the medical card. Please fill in the blanks with the information needed. If you have any questions about what information is needed please either reach out to a member of the pharmacy team or simply attach a copy of the pharmacy benefit card to this letter.

Thank you!
-Joni Forbus, PharmD
Manager, Medicine Shoppe-Joplin
417-781-2332

Pharmacy Billing Information

RX BIN number: ______________________________

RX PCN number: ______________________________

RX ID number: ______________________________

RX Group number: ______________________________

Date of shot: TBA Time: During the school day with forms on file

Forms are due to the office no later than Thursday, October 31st if you want your child to participate.

If you do not have insurance or do not wish to provide that information, you can still have your child participate. Please send a check made payable to the Medicine Shoppe. The cost of the shot is 25.00. Please send this check with your registration form if you are paying for the shot personally.

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Immunization Administration Record and Consent

Last Name: ______________________ First Name: __________________ Birthdate: ______________
Address: ____________________________________ City: ____________ State: ______ Zip: ________
Phone: __________________________ Medicare or Medicaid Number: __________________________
Family Physician Name: _____________________ Address: _____________________________________
City: ____________ State: ______ Zip: ________ Phone: ________________ Fax: __________________

		Yes	No	Other
1.	Are you sick today? (Do you have a fever, diarrhea, or have you vomited?			
2.	Are you allergic to egg or egg products?			
3.	Have you ever had an allergic reaction to a vaccine in the past?			
4.	Are you pregnant or think you may be pregnant?			
5.	Have you been told you have had Guillainn-Barre Syndrome?			
6-8 For Live Vaccines Only				
6.	Have you had a blood transfusion or received blood products such as immune globulin in the last year?			
7.	Have you received another vaccine in the last 30 days?			
8.	Do you or another member of your household have cancer, leukemia, HIV/AIDS, or other immune system problems?			

I have read, or have had explained to me, the information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and authorize the administration of the vaccine to me or the person named below for whom I am authorized to make this decision. I have received a VIS for each vaccine.

I, for myself, my heirs, and my executors release Medicine Shoppe, any retail or external site, physician, and employees, from any and all claims arising out of, or in any way related to my receipt of this or these immunization(s). Medicine Shoppe and the aforementioned related parties shall not at any time or any extent be liable or responsible for any loss, injury, death, or damage to be suffered or sustained at any time as a result of this vaccination program.

I consent the release of this information to my Primary Care Physician as listed above to documented receipt of vaccination.

I agree to wait in the vaccination location for approximately 15 min for observation after vaccination.

______________________________ ______________

Signature Date

☐By checking this box, I decline to have this vaccine registered with ShowMeVax for Missouri.

Vaccine Name	Mfg	Qty	Lot	Exp	Inj Site	Route

Vaccine Administered by:		Date:	