

- Prescriptions
- Compounding
- **FREE** Delivery



- Wellness Classes
- Yoga Classes
- Billing Arrangements

August 2011

**Re: FREE Flu Shots for you and your family members (if covered by your health plan benefit)**

Dear Employees and Family Members,

Ladd Family Pharmacy is making it even easier to get a flu shot so you can stay healthy for the people you care about.


Register for your upcoming employer clinic. When you get your shot, **present your insurance card and the completed form below.** Family members/friends who are **not** covered by your health benefit plan pay \$25 cash.

We are providing convenient access to affordable, preventative healthcare to help you stay healthy and save money. Ladd Family Pharmacy wants you to be able to celebrate those major life moments with your loved ones. Get your flu shot for you and the ones you love today!

Regards,

Elaine (Pharmacist) and Kip Ladd (Business Manager)  
Owners of Ladd Family Pharmacy

-----  
**PLEASE COMPLETE THIS FORM FOR EACH MEMBER WANTING A FLU SHOT**

<b>Name:</b>		<b>Date:</b>
<b>Date of Birth:</b>		<b>Phone:</b>
<b>Address:</b>		<b>City:</b>
<b>State:</b>	<b>Zip:</b>	
<b>Drug Allergies (circle one): Yes or No</b> If YES, please list the names or class of drugs below:		
		
<b>Insurance</b>		
<b>BIN:</b>	<b>ID#:</b>	<b>Person Code (if applicable):</b>
<b>Group#:</b>		<b>PCN# (if applicable):</b>

Vaccines subject to availability. Age and health condition-related restrictions may apply. Flu vaccines may be covered by your health plan benefit.

**Family Member Eligibility:** You are also welcome to bring your dependent family members anytime during business hours (M-F 9 AM to 9 PM, Saturday 9-6 PM, and Sunday 11-5 PN) to receive the same benefit at our convenient location at **1109 S. Broadway Avenue in Boise.**

P 208.947.0877  
F 208.947.0874  
WWW.LADDFAMILYRX.COM

1109 S. Broadway Ave  
Boise, Idaho 83706  
laddrx@gmail.com

**INSURANCE BILLING OPTIONS FOR COMPOUNDING**

- Prescriptions
- Compounding
- *FREE* Delivery



- Wellness Classes
- Yoga Classes
- Billing Arrangements

## Influenza Vaccine Administration Consent Form

I have been given the opportunity to ask questions about the vaccine listed below and my questions were answered to my satisfaction. I have received the appropriate CDC Vaccine Information Statement (VIS) and have read the information or had it read to me. I have received all the information I need to give this informed consent. I have never had a history of hypersensitivity or a life threatening allergic reaction to gelatin, neomycin or to any other component of the vaccine. I have never had a history of hypersensitivity or allergic reaction to dry natural latex rubber.

I understand the benefits, risks and contraindications to this vaccine. I understand, as with all medical treatments, there is no guarantee that I will become immune. I am not immunosuppressed, on hemodialysis, breastfeeding, or pregnant. I am not taking high dose corticosteroids or other immunosuppressive therapy. I do not have active tuberculosis. I will inform my health care provider if I have any current illness, infection or elevated temperature. I understand I may need to postpone the vaccination until I have recovered. I will inform my health care provider if I have received a vaccine or injection recently.

I understand that vaccines, like any medication, can cause mild side effects including soreness/redness at the injection site, fever, headache and body aches. Other reported side effects include bruising, itching at the injection site, diarrhea, runny nose, or rash. I understand that vaccines can in rare instances cause complications, including infection, allergic reaction and death. I also, understand that the chance of serious harm is very rare and that these vaccinations are FDA approved. I agree to accept this risk to decrease my chances of contracting a serious preventable disease. I understand to seek medical attention immediately if I have any difficulty breathing, swelling of the lips, wheezing, hoarseness, fast heart beat, hives, dizziness or swelling of the throat.

### Vaccine to be administered: Influenza vaccine (FluLaval)

\_\_\_\_\_  
 Name of Patient (Please Print Clearly) Date of Birth AGE

\_\_\_\_\_  
 Signature of Patient Date

\_\_\_\_\_  
 Signature of Parent/Legal Guardian Date

Please do not write below this line. **Ladd Family Pharmacy** Authorized personnel only

---

Dose 0.5 ml subcutaneous

FluLaval \_\_\_\_\_ \_\_\_\_\_ RD LD IM \_\_\_\_\_  
 Date Manufacturer Lot#, exp date Injection Site Route Initials

Pneumovax \_\_\_\_\_ \_\_\_\_\_ RD LD IM \_\_\_\_\_  
 Date Manufacturer Lot#, exp date Injection Site Route Initials

P 208.947.0877  
 F 208.947.0874  
 WWW.LADDFAMILYRX.COM

1109 S. Broadway Ave  
 Boise, Idaho 83706  
 laddrx@gmail.com

**INSURANCE BILLING OPTIONS FOR COMPOUNDING**