VACCINATION CONSENT FORM

First Name__________________Last Name ___________________ Date of Birth______________ Age_________

Gender_____Address________________________________City________________St_________Zip__________

Race/Ethnicity (circle all that apply): American Indian, Asian, Black or African American, Hispanic or Latino, White, Other____________

Which vaccines are you requesting to have administered today? (circle all that apply)
Flu Pneumonia Shingles TDAP Other_________________ COVID: J&J Moderna Pfizer

THE FOLLOWING QUESTIONS WILL HELP US TO DETERMINE YOUR ELIGIBILITY TO BE VACCINATED	Yes	No	Unsure
1. Are you feeling sick today?			
2. Do you have any allergies to medications, food, or vaccines? **If so, please list allergies**____			
3. Have you ever had a serious reaction to any vaccine?			
4. Have you received any vaccinations in the past 4 weeks? **List:**_________________			
5. Have you had a seizure, brain or nervous system problem or Guillain-Barre syndrome?			
6. Do you smoke?			
7. Do you have a long-term health problem? (circle all that apply) Asthma COPD Diabetes Cancer Asplenia Cochlear-Implant Spinal-fluid-leak Other____			
8. Are you currently taking a blood thinner or have a bleeding disorder?			
9. Have you ever had a pneumonia vaccination?			
10. Have you ever had a shingles vaccination?			
11. **For Women**: Are you pregnant or considering becoming pregnant in the next month?			
12. Do you take medications that affect your immune system like steroids, anti-cancer drugs, weekly injections, infusions, or radiation?			
13. Do you have or are you around someone with a weakened immune system?			
14. Have you received a blood transfusion or immune globulin in the past year?			
COVID VACCINE ONLY			
15. Have you received a previous dose of COVID vaccine? If yes, which one? Moderna Pfizer J&J Other_____________________			

16. Check all that apply to you

- ○ Had a severe allergic reaction to something requiring use of epinephrine (Epi-pen)
- ○ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ○ Diagnosed with Multisystem Inflammatory Syndrome after COVID-19 infection
- ○ Have a history of heparin-induced thrombocytopenia (HIT)
- ○ Am a female between 18 and 49 years old
- ○ Am a male between ages 12 and 29 years old
- ○ Have a history of myocarditis or pericarditis
- ○ Have received dermal fillers in the last 6 months

Acknowledgement and Consent: I herby give my consent to SKripts Pharmacy to administer the vaccine(s) that I have requested above. I have received, read and/or had explained to me the Vaccine Information Statement on the vaccine(s) I have elected to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I authorize SKripts Pharmacy to (1) release my medical or other information to my healthcare providers, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment (2) submit a claim to my insurer and request payment of authorized benefits be made on my behalf to SKripts Pharmacy with the respect to the above requested items and services and (3) release my health information to the physician responsible for this protocol, my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other healthcare operations.

Signature____ DATE____/____/______