VACCINATION CONSENT FORM

Name: First_____**Middle Initial**_____**Last** _____ **Age** _____**Date of Birth**_____

Address_____**City**_____**St**_____**Zip**_____

Phone_____**Gender**_____ **Ethnicity (circle one): Hispanic or Latino OR Not Hispanic or Latino**

Race (circle all that apply): American Indian, Asian, Black or African American, White, Other_____

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

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 after receiving a 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 have leukemia, HIV/AIDS, or any other immune system problem?			
7. Do you have a long-term health problem with lungs or kidneys or any of the following: Asthma COPD Diabetes Cancer Asplenia Cochlear-Implant Spinal-fluid-leak Other_____			
8. Are you taking a blood thinner, including long-term aspirin, 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 have a health condition that makes you immunocompromised or do you take medications that affect your immune system like steroids, anti-cancer drugs, CAR-T therapy, stem cell transplant, treatment for rheumatoid arthritis, Crohn's disease, or psoriasis, or radiation?			
13. Are you around someone with a weakened immune system?			
14. Have you received blood products, immune (gamma) globulin, or anti-virals in the past year?			
COVID VACCINE ONLY			
15. Have you received a previous dose of COVID vaccine?			

16. Check all that apply to you

- Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)
- Have tested positive for COVID in the past 10 days
- Have received monoclonal antibodies or convalescent plasma for COVID treatment in the past 90 days
- Have a history of myocarditis or pericarditis
- History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia (HIT)

Acknowledgement and Consent: I hereby 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_____/_____/_____