VACCINATION CONSENT FORM

Immunization Location: Circle One: 403 U.S. 24, Buena Vista, CO 81211 OR 137 F St Salida, CO 81201 Date:_____

Patient Name:_____ D.O.B:_____ Age: _____ Gender: Male Female

Address:_____ City/State/Zip:_____/___/_____ Phone:(____)_____

Primary Care Physician:_____ Phone:(____)_____

Address:_____ City/State/Zip:_____/___/_____

Insurance BIN: _____ PCN: _____ Group: _____ ID#:_____ OR Med B#:_____

Before getting a vaccination please *check* YES or NO to the following questions:	Yes	No	Don't know
1. Do you have any cold or flu symptoms today?			
2. Are you allergic to medications, food, or any vaccines? (Examples: Eggs, Bovine Protein, Gelatin, Latex, Gentamicin, Polymyxin, Phenol, or Thimerosal) **If yes, please list the allergies:**			
3. Have you had a serious reaction to a vaccine?			
4. Do you have a chronic condition or long term health problem? Please check all that apply Anemia Asthma Diabetes Heart Disease Kidnev Disease Liver Disease Lung Disease Other:			
5. Have you ever had a neurological disorder or have you been diagnosed with Guillain-Barre Syndrome?			
6. Are you pregnant or considering becoming pregnant in the next month?			
7. Have you received any vaccinations in the past 4 weeks? If yes, please list the vaccination:			
8. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?			
9. Have you taken prednisone, corticosteroids or anticancer medication or received radiation treatment in the past 3 months?			
10. Have you received a blood transfusion or been given immune globulin or antiviral medications in the past year?			

I am providing this consent form to BUENA VISTA DRUG / SALIDA PHARMACY AND FOUNTAIN in order that I may be given the vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the vaccination. I hereby acknowledge that, based on the information presented to me, I am eligible to receive the vaccine on this date. I am feeling well today and I have not recently had a fever. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I hereby acknowledge that I have been offered a copy of the BUENA VISTA DRUG / SALIDA PHARMACY & FOUNTAIN, Notice of Privacy Practices. I release BUENA VISTA DRUG / SALIDA PHARMACY & FOUNTAIN, its employees, representatives and agents from any liability for giving me this vaccination. I agree to indemnify, defend and hold BUENA VISTA DRUG/ SALIDA PHARMACY & FOUNTAIN harmless from any claim. I accept responsibility for seeking medical attention for any problems associated with my receiving this vaccination. I have had the opportunity to have my questions answered. I understand that by signing below I am responsible for payment of this vaccination if my insurance company denies payment to BUENA VISTA DRUG / SALIDA PHARMACY & FOUNTAIN. If the vaccine was paid for by my employer I authorize the pharmacy to share this vaccine history with my employer.

Patient Signature_____ **Date**_____

For Buena Vista Drug/ Salida Pharmacy and Fountain use only

VIS Provided: (Please Circle or prove the version of VIS given) Influenza 8/6/21, PPSV 23 10/30/19, PCV15 2/4/22, PCV20 2/4/22, HepA 10/15/21, HepB 10/15/21, Shingles 2/4/22, Tdap 8/6/21, Td 8/6/21 Other:_____ Date Provided:_____

Immunizer Name: _____ Immunizer Signature: _____

Date of Admin:_____

Vaccine Administered	Lot#	Exp Date	Manufacturer	Dosage	Circle Site of Injection- if not circled shot was administered in Right Arm	Date PNL Sent
Inactivated Influenza (circle one: QID / HD				0.5ml	L / R Deltoid IM	
Tdap (Boostrix)				0.5ml	L / R Deltoid IM	
PPSV23				0.5ml	L / R Deltoid IM	
Shingles (Shingrix)				0.5ml	L / R Deltoid IM	
PCV15 / PCV20 (circle one)				0.5ml	L / R Deltoid IM	
Other:						