PARKER ROAD PHARMACY VACCINATION CONSENT FORM
PATIENT INFORMATION: (Please fill in the blanks as legibly as possible, circle answers, sign, and date)
(Legal) First Name: _____ MI: ____ Last Name: _____SSN: _____DOB:____/_____/_____

Gender: ☐ Male ☐ Female **Phone #: _____ Street Address: _____**

P.O. Box _____ Apt. No. _____ City: _____ State: _____ Zip Code:_____

Race: Black/African American Native Hawaiian/Other Pacific Islander Native American /Alaska Native Asian White Other

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Vaccination Needed: FLU COVID-19 PNEUMONIA T-DAP SHINGRIX HEP B HPV OTHER: _____

Have you had any vaccinations within the last 28 days?	**YES**	**NO**
Do you have a fever and/or feel sick today? Are you currently being quarantined or treated for an active infection or illness?	**YES**	**NO**
Do you have any allergies to medications, vaccination components, (ex: Polyethylene glycol (PEG), Gelatin, Neomycin) foods or latex?	**YES**	**NO**
Have you ever had an immediate severe reaction to a vaccination or injectable medication? Reaction would have occurred within the first 4 hours following vaccination and required EpiPen use, hospital treatment, swelling in the face, mouth or throat, fast heartbeat, full body rash, or dizziness.	**YES**	**NO**
Do you have any long term health conditions such as heart disease, diabetes, lung or kidney disease, anemia or other blood disorders, cancer, AIDS, Or any other moderate to severe immune compromising condition? Have a history of seizure, brain, or nervous system concerns?	**YES**	**NO**
Are you using any steroid treatments, (prednisone, cortisone, etc.) anticancer medications, or undergoing radiation treatment or chemotherapy?	**YES**	**NO**
Within the past year have you received a blood transfusion or any type of blood products? Do you take blood thinners?	**YES**	**NO**
Are you pregnant, breastfeeding or planning on becoming pregnant within the next 3 months? If pregnant, how far along? _____weeks	**YES**	**NO**
For Flu Vaccination: If you are 65 years of age or older, would you like to receive the high dose flu vaccination?	**YES**	**NO**
For COVID-19 Vaccination: Have you received Monoclonal Antibodies or convalescent plasma as part of COVID-19 treatment?	**YES**	**NO**
For COVID-19 Vaccination: Have you already received a dose of the COVID-19 vaccination? YES NO **If yes, which vaccine did you receive? PFIZER MODERNA JANSSEN OTHER: _____** **How many doses have you received? ONE TWO THREE** **Date(s) received: _____/_____/_____ _____/_____/_____ _____/_____/_____**		
For other vaccinations requiring multiple doses: Have you already received a dose of the vaccination? YES NO **If yes, which vaccine did you receive? PNEUMONIA SHINGRIX HEP B HPV OTHER: _____** **How many doses have you received? ONE TWO THREE** **Date(s) received: _____/_____/_____ _____/_____/_____ _____/_____/_____**		

RELEASE, ASSIGNMENT, AND INSURANCE AUTHORIZATION: I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine, or the Vaccine Information Sheet (VIS) and I am aware of the risks and benefits. I give consent to this provider/staff for the individual named above to be vaccinated with the vaccination indicated. I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice. I understand that information about this vaccination will be included in (WebIZ) Arkansas Immunization Information System. I authorize the release of any medical information necessary to process my insurance claim(s) and request payment of medical benefits directly to this vaccination Provider. I agree that the authorization will cover all medical services rendered until I revoke the authorization. I agree that the photocopy of this form may be used instead of the original. I have received a Well Child Visit brochure if the patient is age 17 or under and is getting a COVID vaccination. I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.

X Signature of Patient/Parent/Guardian_____**DATE**_____

VACCINE ADMINISTRATION (Completed by staff only)

Vaccine Administered (circle one): FLU COVID-19 PNEUMONIA T-DAP SHINGRIX HEP B HPV OTHER: _____					
Route	**Site Code**	**Dosage mL**	**Brand (ie: Boostrix)**	**Lot Number**	**Expiration Date**
☐ **IM** ☐ **SUB-Q**					
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Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: _____ Date Vaccine Administered: _____/_____/_____