☐ Faxed to PCP, Date: _____, Initials: _____
☐ Entered in IRIS, Date: _____, Initials: _____
☐ Entered in PW, Date: _____, Initials: _____

IMMUNIZATION CONSENT

**Telepharmacy Patients: Patients may be video recorded for technician vaccination accuracy checks.

Patient Name _____ Birth Date _____ Phone _____
Address _____ City, State _____ Zip Code _____
Primary Care Provider _____ Provider's Phone # _____

Questions to help determine eligibility for vaccination	Yes	No	Don't Know
1. Which vaccine(s) or immunization are you receiving today? (please circle) **Flu Shot** **Flu Nasal Spray (2-49 yrs)** **Flu High Dose (65+)** **Pneumonia** **Other:** **Shingles** **Tetanus/Pertussis** **Covid-19 25-26** **RSV** **Hep B 1st** **Hep B 2nd (1 month)** **Hep B 3rd (6 month)** *Can keep SAME consent form for multiple series vaccinations, document below.			
2. Do you feel sick today?			
3. Do you have allergies to medications, food, or vaccines? (please list)			
4. Have you received any vaccinations or skin tests in the past 4 weeks? (please let pharmacist know)			
5. Have you ever had a serious reaction after receiving a vaccination?			
6. Do you have any of the following long term health problems: (please circle) **anemia** **asthma** **diabetes** **blood disorder** **heart disease** **kidney disease** **liver disease** **lung disease** **other:**			
7. Do you have cancer, leukemia, AIDs, or any other immune system problems?			
8. Are you currently taking high-dose steroid therapy* for longer than two weeks? *e.g. prednisone >20mg/day or equivalent			
9. Have you had a seizure, Guillain-Barre syndrome, or do you have a brain or nervous system problem?			
10. During the past year, have you received a transfusion of blood, blood products, or been given immune (gamma) globulin or an antiviral drug?			
11. **WOMEN**: Are you pregnant or is there a chance you could become pregnant within the next month?			
12. Are you a healthcare worker?			
13. Do you take any medications that thin your blood or could cause you to bleed more easily (aspirin, warfarin, Xarelto, Plavix, etc.)			
14. Are you currently on home infusions or weekly injections*, high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments? *Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actermra, Cytoxan, Rituxan, adalimumab, infliximab, etanercept			
15. Have you ever had a shingles vaccine (age > 50 years)?			
16. Have you ever had a pneumonia vaccination (age ≥ 65, those who smoke, and those who have a long term health problem)?			
17. **FluMist**: Do you have a nasal condition making breathing difficult, such as a stuffy nose?			
18. **FluMist**: If the patient is < 5 yrs, is there a history of asthma or wheezing?			
19. **Covid-19:** Do you have any symptoms of Covid-19? (e.g. loss of taste, cough, shortness of breath)			

I certify that I have been given a copy of the FDA approved Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) education. I have read the VIS or EUA and have had a chance to ask questions of a qualified health provider. I understand the benefits and risks of the vaccination I am receiving and request that the vaccine be given to me or the person named below for whom I am authorized to sign. I certify that I am (1) the patient and at least 18 years of age (2) the parent or legal guardian of the minor patient (3) the legal guardian of the patient. I understand that it is not possible to predict all possible side effects or complications associated with the vaccine. I acknowledge that I have been advised to stay in the area that the vaccine was given in for at least 15 minutes for observation to ensure a severe reaction does not occur. I understand that the information regarding my vaccination will be reported to the State Registry and to my insurance company (if applicable).

Patient Signature: _____ Date: _____
Parent or Guardian Signature: _____ Date: _____
***If the vaccination is not covered by insurance, patient will be responsible for full cash price payment of the vaccination.*

FOR HEALTHCARE PROVIDER USE ONLY:

Name of Site/ Clinic: **NUCARA PHARMACY** Immunizer Name: _____
Immunizer Signature: _____ Date _____

Vaccine	Lot #	Exp Date	Manufacturer	Dose	Site of Injection	VIS Date	RPh Initials