Respiratory Syncytial Virus (RSV) Vaccination Consent Form and Record (2024-2025)

Please complete and return this form (PLEASE PRINT)

Aston Pharmacy Home Health Center
"Where caring is the heart of our business"

PERSONAL INFORMATION:	
	PATIENT NAME:
	DATE OF BIRTH: **Phone #**
	ADDRESS:
	Primary Physician:

Please circle Yes or No to each question below:

1. Are you 75 + years of age? If you are, skip to question 2	**Yes**	**No**
1a. Are you 60-74 years of age and at an increased risk for RSV? Risk factors include chronic heart or lung disease; weakened immune system; certain other medical conditions, including severe obesity and severe diabetes; live in a nursing home or other LTC facility.	**Yes**	**No**
2. Are you currently sick with a fever, vomiting or diarrhea?	**Yes**	**No**
3. Are you allergic to messenger ribonucleic acid (mRNA), lipids (PEG 2000 DMG, cholesterol, and DSPC), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate trihydrate, mannitol, polysorbate 80, sodium chloride or sucrose?	**Yes**	**No**
4. Have you ever had a serious reaction to any vaccine which required medical care?	**Yes**	**No**
5. Are you taking any blood-thinning medications (i.e. aspirin, warfarin, etc)?	**Yes**	**No**
6. Have you ever fainted or felt dizzy after receiving a vaccine?	**Yes**	**No**
7. Have you ever had Guillain-Barŕe syndrome?	**Yes**	**No**
8. Are you allergic to Latex?	**Yes**	**No**
9. Do you have an immunocompromising condition (e.g. cancer, leukemia, lymphoma, HIV/AIDS, transplant) functional, or anatomic asplenia, CSF leak or cochlear implant or take a medication (e.g., steroids or chemotherapy) that lowers the body's resistance to infection?	**Yes**	**No**
10. Are you pregnant or nursing?	**Yes**	**No**
11. Please let us know if you have close contact with anyone who has a weakened immune system and must be in a protective environment (eg, an individual who has had a bone marrow transplant).	**Yes**	**No**
12. Have you received a vaccine within the past 30 days? If yes, please list name of vaccine(s): _____ Dates: _____	**Yes**	**No**

Note: If you answered NO to questions 1 and/or 1a, you are not eligible to receive the RSV vaccine. If you answered YES to questions 2,3,4 or 7 you should not receive the RSV vaccine.

I have been given the Centers for Disease Control and Prevention Vaccine Information Sheets. I have read these documents and have no further questions at this time. I understand the risks and benefits of the vaccine. I request and voluntarily consent to receiving the influenza vaccine and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine and consent to emergency treatment if needed.

Allergies or medical alert: _____

Patient Signature or POA signature & name: _____ **Date:** _____

For Clinic Use Only

Vaccine	Manufacturer	VIS Date	Lot #	Exp Date	Site/Route	Dosage Vol
☐ mRESVIA®	Moderna	10/19/2023			LD RD IM	0.5 mL
☐ ABRYSVO®	Pfizer Inc.	10/19/2023	drug: diluent:		LD RD IM	0.5 mL

Signature of Vaccine Administrator: _____ **Administration Date:** _____

For office use only: ____ Billed ____ Scanned ____ PA SIIS ___ Faxed doctor *09/16/2024*