Immunization Consent Form

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	GENDER (M/F)
ADDRESS	CITY	STATE	ZIP
10-DIGIT PHONE NUMBER	MEDICARE ID NUMBER		BIRTH DATE (MM/DD/YY)
PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN ADDRESS	PRIMARY CARE PYSICIAN PHONE/ FAX	VACCINE REQUESTED

CASE HISTORY AND LISTED CONTRAINDICATIONS (Please circle YES, NO, or DON'T KNOW for each question)

ALL VACCINES

1. Have you had a physical examination within the Past year?.....YES NO DON'T KNOW
2. Are you sick today?.....YES NO DON'T KNOW
3. Do you have allergies to medications, eggs or other food, a vaccine component, or latex?.....YES NO DON'T KNOW
   If yes list allergies_____
   _____
   _____
   _____
   _____
4. Have you ever had a serious reaction after receiving a vaccination?.....YES NO DON'T KNOW
5. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? .....YES NO DON'T KNOW
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?.....YES NO DON'T KNOW
7. Have you had a seizure, brain disorder, Guillian-Barre Syndrome or other nerve problem?.....YES NO DON'T KNOW

LIVE VACCINES

8. In the past 3 months, have you taken any medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?.....YES NO DON'T KNOW
9. During the past year, have you received a transfusion of blood or blood products, or been given a immune (gamma) globulin or an antiviral drug .....YES NO DON'T KNOW
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?.....YES NO DON'T KNOW
11. Have you received any vaccinations in the past 4 weeks? .....YES NO DON'T KNOW
    If yes, what vaccines?
    _____
    _____
    _____

FOR PHARMACY USE ONLY

I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient ('Ward'). I have received a copy of the applicable Vaccine Information Statement[s] and I have read the adverse reactions associated with the administration of vaccine[s]. Furthermore, I consent to the administration of the vaccine[s] requested above to me or my Ward and acknowledge that, as a condition to administration of the vaccine[s], myself or my Ward must remain under the observation of the administering pharmacist for a period of not less than 15 minutes. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about the immunization[s]. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization[s] or the receipt of the immunization[s] by the person named above for whom I am the Ward. My medical record, may be shared with my primary care provider or other healthcare provider and the medical record of my Ward may be shared with his/her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release BUCHANAN DRUGS, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization[s]. Neither BUCHANAN DRUGS nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine[s] described above. I authorize BUCHANAN DRUGS to (a) notify my or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (3) make any other disclosures required by law. BUCHANAN DRUGS will use and disclose your personal and health information or the personal and health information of your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

For Patients receiving Live Vaccines only: I further certify that I have read the list of contraindications to the vaccine[s] set forth above and neither me or my Ward have a contraindication to the vaccine[s] to be administered.

_____

_____

SIGNATURE/LEGAL GUARDIAN DATE OF VACCINATION/DATE VIS GIVEN

_____

PRINT

Immunization Consent Form

ADMINISTRATIVE RECORD (For Pharmacy Use ONLY)

VACCINE: _____	EXPIRATION DATE: _____	VACCINE: _____	EXPIRATION DATE: _____	VACCINE: _____	EXPIRATION DATE: _____
VIS VERSION/DATE: _____	DATE ADMINISTERED _____	VIS VERSION: _____	SITE OF INJECTION: _____	VIS VERSION: _____	SITE OF INJECTION: _____
MANUFACTURER: _____	DOSAGE: _____	MANUFACTURER: _____	DOSAGE: _____	MANUFACTURER: _____	DOSAGE: _____
LOT NUMBER: _____	ROUTE OF ADMIN: _____	LOT NUMBER: _____	ROUTE OF ADMIN: _____	LOT NUMBER: _____	ROUTE OF ADMIN: _____
BRAND NAME: _____	DATE NEXT VACCINE DUE (IF APPLICABLE): _____	BRAND NAME: _____	DATE NEXT VACCINE DUE (IF APPLICABLE): _____	BRAND NAME: _____	DATE NEXT VACCINE DUE (IF APPLICABLE): _____
DATE ADMINISTERED: _____	DATE M.D. NOTIFIED _____	DATE ADMINISTERED: _____	DATE M.D. NOTIFIED _____	DATE ADMINISTERED: _____	DATE M.D. NOTIFIED _____

PAYMENT INFORMATION

VACCINE FEES:	TOTAL CHARGE:

ADMINISTERING PHARMACIST INFORMATION

PHARMACIST NAME, TITLE & LICENSE NUMBER: **CIRCLE ADMINISTERING PHARMACIST INFORMATION**

PATRICK COOK, PIC, RPH020833 / NICOLE GRIFFITH, STAFF, RPH021634 / GINGER WILLAMSON, STAFF, RPH018329

LAURIE MCMILLIAN, STAFF, RPH026318 / JAMES RAINS, STAFF, RPH014868 /

_____

ADDRESS: TELEPHONE NUMBER

BUCHANAN DRUGS 770-646-3570

106 COURTHOUSE SQUARE
BUCHANAN, GA 30113

FOR PHARMACY USE ONLY

ADVERSE EVENTS/COMPLICATIONS & NOTES
Report all adverse reactions to the Federal Vaccine Adverse Event Reporting System