Delta
Pharmacy & Medical Supply
Since 1935

IMMUNIZATION CONSENT FORM

NAME: _____ BIRTH DATE: ____/____/____ AGE:_____ SEX: M / F_____

ADDRESS:_____ CITY:_____STATE: ____ZIP:_____

PHONE: (_____) _____ MEDICARE ID: _____

PRIMARY CARE PHYSICIAN: _____ Dr. PHONE NUMBER: _____

	The following questions will help us better determine which vaccines you are eligible for:	YES	NO	DON'T KNOW
ALL VACCINES	1. Do you feel sick today? If yes: (Do you have a new fever, cough, diarrhea and/or vomiting?)			
	2. Do you have allergies to latex, medications, food, or vaccines? (Example eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, or thimerosal) **If yes, please list:**			
	3. Have you ever had a reaction after receiving a vaccination?			
	4. Have you ever fainted or felt dizzy after receiving a vaccine?			
	5. Have you received any vaccinations or skin tests in the past four weeks? **If yes, please list:**			
	6. Do you have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?			
	7. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain- Barre syndrome or other nervous system problems?			
	8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
	9. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?			
LIVE VACCINES	10. Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xelijanz, Orencia, Arava, Actermra, Cytoxan, Rituxan, adalimumab, infliximab, or etanercept), high dose methotrexate, azathioprineor 6- mercaptopurine, antivirals, anticancer drugs or radiation treatment?			
	11. Do you live with or expect to be in close contact with anyone who has a severely weakened immune system?			
	12. Are you currently taking high dose steroid therapy (prednisone >20mg.day or equivalent) for longer than two weeks?			
	13. During the past year, have you received a transfusion of blood, blood products including antibodies or been given immune (gamma) globulin?			

Consent for Vaccine Administration

1. I understand Delta Pharmacy is providing vaccine(s) to me in a safe and convenient setting.
2. This does not take the place of an ongoing relationship with my primary care provider.
3. The Delta Pharmacy will provide your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal records with you to your next appointment.

ACKNOWLEDGEMENTS

I acknowledge and attest to the following:

- I have read and understand the Vaccine Information Statement including information on adverse reactions that I may experience as a result of receiving the vaccine. I have had the opportunity to ask the pharmacist questions concerning the vaccine and the Vaccine Information Statement, and my questions have been answered to my satisfaction.
- I have received the Notice of Privacy Practices disclosing my rights to my medical information.
- I have answered the above questions truthfully. By answering yes, the pharmacist may choose to not vaccinate, or I may be at a greater risk for adverse reactions.
- I understand it is not possible to predict all possible side effects or complications associated with receiving vaccine(s).
- If I have insurance coverage, I am responsible for providing the correct information and take responsibility for all copayments and deductibles.
- I voluntarily agree and consent to be immunized by the pharmacist.
- Delta Pharmacy shall not, at any time, or to any extent allowable by applicable law, be liable, responsible, or in any way be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, the administration of the Vaccine to me by the pharmacist.
- I have been advised to remain near the vaccination location for approximately **20 minutes** after administration for observation.

Vaccine Recipient's Name: _____ Date of Birth _____

Vaccine Recipient Legal Representative's Name if under 18: _____

Vaccine Recipient or Vaccine Recipient's Legal Representative:

Signature:_____ DATE: _____