10801 Lockwood Dr. suite 190

Silver Spring, MD 20901

Patient name: ________________________________ Date: ____________________

Please read questions below. Indicate Yes or No for the person receiving a vaccine today.

		Yes	No
1.	Have you/patient ever had a severe reaction to any vaccine, which required medical care?	------	------
2.	Are you/patient allergic to egg, baker's yeast, streptomycin or neomycin?	------	------
3.	Do you/patient have fever, diarrhea or vomiting today?	------	------
4.	Are you/patient or anyone in the home being treated with chemotherapy, radiation for cancer, have HIV/AIDS, or any immune deficiency disease?	------	------
5.	Your PCP (Primary Care Doctor) info: - Name: - Tel:		
6.	Have you/patient had immune globulin or blood transfusion in the past year? If yes, when?	------	------
7.	Are you/patient pregnant, or planning to get pregnant in the next three months ----- N/A	------	------
8.	Please, list all prescriptions or over the counter medications that you/patient are currently taking ---		

Please, flip page to continue

9. Do you have any allergies to medications? ---- yes ---- No
   If yes, please list all medications you are allergic to:

. Consent of Administration of vaccine

------ COVID ------ RSV

------ Influenza (Flu shot) ------ Tdap

------ Pneumonia ------ Shingrix

Pregnancy consent:

I understand that CDC approved the RSV vaccine for pregnant women of 32 through 36 weeks. Hereby I consent that, as of today -- / -- / ---- (MM/DD/YYYY) , I'm within the 32 to 36 weeks of pregnancy, which approves my eligibility for the RSV vaccine.

Signature:______________________

Arm: Left --- Right ----

I have read, or have had read to me, the information regarding the vaccine/vaccines marked above. I have had the opportunity to ask questions that were answered to my satisfaction, I understand the benefits and risks of the vaccine/vaccines, I consent to OR give consent for the administration of the vaccine/vaccines marked above to:

Patient's name (print): ___________________________________

Address: _______________________________________

Date of birth: ___________________________________

Tel. number: ____________________

Relationship to patient: ----Self ----other If other, Your name:_________________

Signature: _________________________ Relationship to patient: _______________

To be filled out by the Pharmacist
Vaccine Lot number: Expiration date: Notes: R.Ph. signature: Date: