VACCINE ADMINISTRATION CONSENT FORM

PLEASE MARK Vaccine Requested:

Capitol Heights Pharmacy
1200 Madison St. Denver, CO 80206
p. 303-388-3679 f. 303-393-7604

□ **Flu** □ **Adult Covid** □ **Child Covid**
□ **Tetanus** □ **Shingles** □ **Pneumonia**
□ **RSV** □ **Hepatitis B** □ **Other**_____

Name: _____ Gender:_____ DOB:_____Age:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Allergies (to meds):_____**If >65 Last 4 of SSN:**_____Race:_____

Screening Questions:

1. Are you sick today? Yes No
2. Do you have allergies to medications, food, eggs, yeast, a vaccine component, polysorbate, PEG or latex? Please list if yes: _____ Yes No
3. Have you ever had a serious reaction after receiving a vaccination? Yes No
4. Has any physician or other healthcare professional ever warned you about receiving vaccines outside of a medical setting? Yes No
5. Do you have any of the following conditions? Yes No
   □ Cancer □ CVD □ Kidney Disease □ Asthma/COPD □ Disabled □ Diabetes □ Heart Disease □ ADHD
   □ Blood Disorder □ HIV □ Overweight/Obese □ Sedentary Lifestyle □ Pregnant □ Smoker □ Immunocompromised
6. Have you ever been diagnosed with multisystem inflammatory syndrome or had myocarditis or pericarditis within 3 weeks of receiving a Covid vaccine? Yes No
7. In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, anticancer drugs, or radiation? Yes No
8. Have you had a seizure, brain, nervous system problem or Guillain Barre? Yes No
9. Are you pregnant? If so, how many weeks are you? _____ Yes No
10. Do you have a history of fainting, particularly with vaccines? Yes No
11. Have you had a past reaction to gelatin or triple antibiotic ointment? Yes No
12. Have you had any dermal fillers (Juvederm, Restylane, etc) recently? Yes No
13. Have you received a covid vaccine in the past 2 months? Yes No

I have read or have had read to me the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits of the vaccine(s). I consent to or give consent for the administration of the vaccine(s) requested. I authorize this information to be forwarded to my primary care provider, authorizing physician or local Department of Health if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case immediate reaction occurs. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Capitol Heights Pharmacy, its officers, employees, agents, and owner of clinic site from any and all liability that might arise from the vaccination(s) on behalf of myself, my heirs, and personal representative.

_____ _____
Signature of Patient or Parent/Guardian of Minor Patient Date

_____ _____
Please print name of Parent/Guardian if patient is a minor Relationship to Patient