Capitol Heights Pharmacy
Informed Consent to Receive Vaccines

Name Mr/Mrs/Ms _____ _____Date of Birth_____ Male/Female

Street Address_____City_____State_____ Zip_____

Home Phone_____Physician's Name_____ Physician's Address_____

Please check yes or no to the following questions. If any questions are unclear, please ask for assistance

	Yes	No
1. Do you have a fever, diarrhea, or vomiting today?	_____	_____
2. Are you allergic to eggs, baker's yeast, preservatives? (ex: sulfates) thirmerosol, streptomycin, neomycin or latex	_____	_____
3. Have you ever had a severe reaction to any vaccine which required medical care?	_____	_____
4. Are you or anyone in your home or anyone in your care treated with chemotherapy, radiation for cancer?	_____	_____
5. Have you had Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?	_____	_____
6. Have you had Guillain-Barre Syndrome, a condition which causes paralysis?	_____	_____
7. For women, are you pregnant or planning a pregnancy in the next month?	_____	_____
8. Are you taking any blood thinning medications (ex. aspirin, warfarin, etc?)	_____	_____
9. Do you have any of the following conditions: asthma, heart disease, diabetes, brain, spinal cord or muscle illness that causes swallowing or lung problems with immune system caused by medications and or HIV, kidney disease, liver disease, blood disorders or chronic diseases?	_____	_____

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 be forwarded to my primary care provider, authorizing physician or local Department of Health in 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 (store name), it's officers, employees and agents, the owner and/or operator of the clinic site, it' officers, employees and agents from any and all liability that might arise from this vaccination(s) on behalf of myself, my heirs and personal representative.

Patient's Signature_____ Date_____

Parent / Guardian Signature _____ Date_____

Please sign below that you have been offered / received our Notice of Privacy Practice for HIPAA

Signature_____ Date_____

Vaccine Lot # Exp. Date Manufacturer

_____administered in right or left arm _____ _____

Dose (ml) Admin. Date VIS Date

_____ _____

Administrator Name Pharmacy Name