Pharm A Save Monroe
17788 147th ST SE
Monroe, WA 98272

Vaccine Consent Form

Clinic Yes___No _

Patient Information (Please fill out completely)

Name:_____**Date of Birth:**_____**Phone #**_____

Address: _____

City:_____**State:**_____**Zip**_____

Primary Care provider: _____

Allergies: _____

Medical Conditions: _____

Requested Vaccines: _____

Insurance BIN_____ ***PCN***_____***GRP***_____***ID*** _____

"I have read or have had explained to me the information in the CDC vaccine information statement(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this/these vaccines and ask that the vaccine(s) be given to me"

_____**check here if you do not wish your primary care provider notified of this vaccination**

******************************Pharmacy use only*******************************

Vaccines Administered

__Influenza Injectable	**__Shingrix**	**__Varicella**
__Influenza Nasal	**__MMR**	**__Prevnar 13**
__Pneumovax 23	**__Twinrix (Hep A and B)**	**__IPV**
__Hepatitis A	**__Tdap**	**__Meningococcal**
__Hepatitis B	**__Oral Typhoid**	**__Hib**

Other _____

_____

LOT # _____
EXPIRATION:_____
ADMIN SITE: LA or RA

LOT # _____
EXPIRATION:_____
ADMIN SITE: LA or RA

LOT # _____
EXPIRATION:_____
ADMIN SITE: LA or RA

Pharmacist:_____License #_____NPI: _____

Substitution Permitted_____Dispense AS Written _____

*Signature of pharmacist who administered the vaccine and provided VIS to patient and Date _____

Screening Questionnaire

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.	**YES**	**NO**
Are you Sick today?		
Do you have allergies to medications, food, a vaccine component, or latex?		
Have you experienced a serious reaction after receiving a vaccine in the past?		
Have you received any vaccinations in the last 4 weeks?		
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
Do you have a seizure or other disorders that affect the brain or have had a disorder that resulted from a vaccine?		
Do you take prednisone, other steroids, anticancer drugs, or have you had radiation treatments?		
Are you currently taking antibiotics or antimalarial medications?		
During the past year, have you received a transfusion of blood or blood products, or been given immune globulin or an antiviral drug?		
Do you have a history of thrombocytopenia or thrombocytopenia purpura?		
Are you a parent, family member, or a caregiver to new born infant?		
<u>For Women</u>: Are you pregnant or could you become pregnant in the next three months?		
Did you bring your Immunization Record Card with you?		

Signature:_____**Date:** _____