

Immunization Consent Form

PATIENT INFORMATION

PATIENT'S LAST NAME PATIENT'S FIRST NAME MI GENDER (M/F) BIRTH DATE (MM/DD/YYYY) ETHNICITY

ADDRESS CITY STATE ZIP

10-DIGIT PHONE NUMBER PRIMARY CARE PROVIDER (MD, DO, NP, PA) PROVIDER PHONE/FAX

INSURANCE INFORMATION

MEDICARE # SOCIAL SECURITY # PHARM INS PLAN NAME

RX INS BIN # RX INS PCN RX INS ID # RX INS GROUP #

VACCINE(S) REQUESTED

- | | | |
|---|---|--|
| ☐ Influenza injectable | ☐ Hepatitis A & B | ☐ Whooping Cough (Tdap, DTaP) |
| ☐ Pneumococcal | ☐ HPV | ☐ Measles Mumps & Rubella (MMR) |
| ☐ Meningococcal | ☐ Polio | ☐ Tetanus (Td) |
| ☐ Hepatitis A | ☐ Varicella (Chickenpox) | ☐ Covid-19 - Moderna |
| ☐ Hepatitis B | ☐ Zoster (Shingles) | ☐ Covid-19 - Pfizer |

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question)

- Are you sick today? _____ ☐ Yes ☐ No
- Do you have allergies to medications, food or vaccines? _____ ☐ Yes ☐ No
Allergies _____
- Have you ever had a serious reaction after receiving an immunization? _____ ☐ Yes ☐ No
- Have you ever fainted or felt dizzy after receiving an immunization? _____ ☐ Yes ☐ No
- Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? _____ ☐ Yes ☐ No
- Are you currently being treated for cancer, leukemia, AIDS or any other immune system problem? _____ ☐ Yes ☐ No
- Are you currently taking cortisone, prednisone, other steroids or anti-cancer drugs, or radiation treatments? _____ ☐ Yes ☐ No
- Do you have history of Guillain-Barre Syndrome or Bell's Palsy? _____ ☐ Yes ☐ No
- Have you had a seizure, brain or nerve problem? _____ ☐ Yes ☐ No
- During the past year, have you received a transfusion or blood or blood products, or been given a medicine called immune (gamma) globulin? _____ ☐ Yes ☐ No
- For women: Are you pregnant or is there a chance you could become pregnant during the next month? _____ ☐ Yes ☐ No
- Have you received any vaccinations in the past 4 weeks? _____ ☐ Yes ☐ No
If yes, what vaccines? _____
- Are you allergic to eggs? _____ ☐ Yes ☐ No
- Are you allergic to latex? _____ ☐ Yes ☐ No
- Have you had a physical examination in the past year? _____ ☐ Yes ☐ No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small.

Local vaccine symptoms may include tenderness, redness, itching or swelling at the site of injection. Systemic symptoms may include fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitivity reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after the vaccination, see a doctor right away. Signs of a potentially very serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient ('Ward'). I have received a copy of the applicable Vaccine Information Statement(s) and I have read the adverse reactions associated with the administration of vaccine(s). Furthermore, I consent to the administration of the vaccine(s) requested above to me or my Ward and acknowledge that, as a condition to administration of the vaccine(s), I or my Ward must remain under the observation of the administering pharmacist / nurse for a period of not less than 15 minutes. I understand that a copy of the vaccine manufacturer's drug information sheet is available upon request. Furthermore, I have also had an opportunity to ask questions about the immunization(s). I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named above for whom I am Ward. My medical record may be shared with my primary care provider or other healthcare provider, and the medical record of my Ward may be shared with his / her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Lacey Drug Co. Inc., and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt of my Ward of this or these immunization(s). Neither Lacey Drug Co. Inc., nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine(s) described above. I authorize Lacey Drug Co. Inc. to (a) notify my or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (c) make any other disclosures required by law. I understand that Lacey Drug Co. Inc. will use and disclose my personal and health information or the personal and health information of my Ward, to receive payment of the care they provide and for other health care operations. Healthcare operations generally include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

X

SIGNATURE / LEGAL GUARDIAN

PRINT NAME

ADMINISTRATIVE RECORD For pharmacy use only

DATE OF VACCINATION / DATE VIS GIVEN _____		☐ Lacey Drug Company 4795 S. Main Street Acworth, GA 30101 P: 770-974-3131 F: 678-214-6109	☐ Lacey's LTC 4469 Lemon Street Acworth, GA 30101 P: 678-236-0400 F: 678-236-0404	☐ Lacey's Marietta Pharmacy 790 Church Street #210 Marietta, GA 30060 P: 770-424-3131 F: 770-691-3363	
PHARMACIST / PRESCRIBER SIGNATURE _____					
VACCINE: _____	SITE OF INJ: _____	VACCINE: _____	SITE OF INJ: _____	VACCINE: _____	SITE OF INJ: _____
LOT NO: _____	EXP. DATE: _____	LOT NO: _____	EXP. DATE: _____	LOT NO: _____	EXP. DATE: _____
RT OF ADMIN: _____	MFR: _____	RT OF ADMIN: _____	MFR: _____	RT OF ADMIN: _____	MFR: _____
VIS VERSION: _____	DOSAGE: _____	VIS VERSION: _____	DOSAGE: _____	VIS VERSION: _____	DOSAGE: _____