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

Vaccine Consent Form

Clinic Yes__No _

Patient Information (Please fill out completely) **Today's Date:**_____

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

Parent or Guardian:_____**Email:** _____

Address: _____

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

Patient Race: (Please check)

__ White __ Asian __ Black or African American __ Native Hawaiian or Pacific Islander __ American Indian or Native Alaskan

Patient Ethnicity (Please Check) __ Non-Hispanic __ Hispanic

Do you have any allergies? _____

I am here for the following vaccines today:

_____ Influenza 65+ yrs

_____ Influenza 5-64 yrs

_____ Covid Booster

___ 5yr-11yr
___ 12+ yr
___ 18+ yr

___ Shingrix _ 1st dose _ 2nd dose

____ Pneumonax 23 ___ Prevnar 20
____ Tdap (Tetanus Diph Pertussis)
____ Hepatitis A ___ MMR
____ Hepatitis B ___ Meningitis
___ RSV

___ Other _____

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

Signature _____ Relationship to Patient_____ Date: _____

****

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

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

VACCINE _____
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:** _____