



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 _____

<p>Patient Race: (Please check) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> American Indian or Native Alaskan</p> <p>Patient Ethnicity (Please Check) <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic</p>

Do you have any allergies? _____

I am here for the following vaccines today:

_____ Influenza 5yrs - 64yrs of age

_____ Influenza **65+yrs of age**

_____ Covid 12yrs+ 1st or 2nd dose
 Pfizer 12+ Moderna 18+

_____ Covid 5yrs-11yrs 1st or 2nd dose

_____ **Covid Booster**
 5yr-11yr Pfizer
 Pfizer Bivalent 12+
 Moderna Bivalent 18+

_____ Shingrix 1st dose 2nd dose

_____ Pneumonax 23 Prevnar 20

_____ Tdap (Tetanus Diph Pertussis)

_____ Hepatitis A MMR

_____ Hepatitis B

_____ 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: _____