

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 # _____

Parent or Guardian: _____ Relationship _____

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"

*Vaccines administered will be reported to the Washington State Immunization Registry

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

Vaccines Administered

<input type="checkbox"/> Influenza Injectable	<input type="checkbox"/> Shingrix	<input type="checkbox"/> Varicella
<input type="checkbox"/> Influenza Nasal	<input type="checkbox"/> MMR	<input type="checkbox"/> Prevnar 13
<input type="checkbox"/> Pneumovax 23	<input type="checkbox"/> Twinrix (Hep A and B)	<input type="checkbox"/> IPV
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Tdap	<input type="checkbox"/> Meningococcal
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Oral Typhoid	<input type="checkbox"/> 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: _____