VIENNA DRUG CENTER, INC.
150 MAPLE AVENUE WEST
VIENNA, VIRGINIA 22180
Phone 703-938-7111
Fax 703-938-5242
viennadrug@aol.com

FLU & Pneumonia Informed Consent Form

Today's Date: _____ Name: _____

Address: _____

Cell# / Phone#: _____ Birth date: _____

Medicare ID Number: _____

Temp Check- _____ (max safe temp 100.4)	Yes	No
1. Are you sick today?		
2. Do you have allergies to medications, food, a vaccine component, or latex? (If yes, please list)		
3. Have you ever had a serious reaction after receiving a vaccination?		
4. Have you had in the last 6 weeks: a seizure, brain, or other nervous system problem (i.e. Guillian-Barre Syndrome)?		

I have read the adverse reactions associated with the vaccine I am about to receive. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. My medical record may be shared with my physician/insurance. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release Vienna Drug Center, any retail site, grocery store, pharmacy, corporation, physician, and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents, employees, and their employees from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). Vienna Drug Center and the other aforementioned parties shall not 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 vaccines described above.

x_____ _____
Signature / Legal Guardian Date

_____ _____
Print Name Administrator

Vaccine: Afluria QUAD/ Fluad quad 65 yrs and older Lot#: P100240196 279784 Mfr: Seqirus

Vaccine: Prevnar 13/ Pneumovax 23 Lot#: _____ Mfr: Pfizer/ Merck

VIS Date: Aug 15, 2019 Oct 13, 2019 Site _____ Arm Date VIS Given: _____

Please wait in community room for 15 minutes after the shot has been administered so we can monitor you for any adverse reactions.

Last Updated 9/4/20

RX LABEL HERE

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Vaccine Administration Record for Children, Teens and Adults

Patient Name:_____

Birth date:_____

Vaccine	Type of Vaccine	Date Given	Site	Vaccine		Vaccine Information Statement		Signature of Vaccinator
				Lot	Mfr.	Date on VIS	Date Given	
Human Papillomavirus (HPV) (give IM) 0, 2M, 6 months	Gardasil-9				Merck	10/30/19		
Hepatitis A&B 0, 1, 6 months	Twinrix				GSK	7/20/16		
Hepatitis A (give IM) 0, 6-12 months	Havrix				GSK	7/28/20		
Hepatitis B (give IM) 0, 1-2M, 6 months	Engerix B				GSK	8/15/19		
Influenza Adjuvanted (IM, 65+)	FLUAD 65+ 2020-2021			279785	Seqirus	8/15/19		
Influenza (Quadrivalent, IM)	Afluria QUAD 2020-2021			P100240196	Seqirus	8/15/19		
Meningococcal (MenACWY) (give IM)	Menactra (9 mos- 55) Menveo (2 mos-55)				SP	8/15/19		
Meningococcal Group B Vaccine (give IM)	Trumenba (10y-25y) Bexsero (10y-25y)				Pfizer	8/15/19		
Measles, Mumps & Rubella (MMR II)(give SC)	MMR II				Merck	8/15/19		
Pneumococcal (PPSV23, Polysaccharide) (give SC or IM)	Pneumovax 23				Merck	10/30/19		
Pneumococcal 13-Valent (PCV13) (give IM)	Prevnar 13				Pfizer	10/30/19		
Tetanus, Diphtheria, Pertussis (give IM)	Boostrix Adolescent thru 65+				GSK	04/01/20		
Tetanus, Diphtheria (give IM)	Decavac (Td)				SP	04/01/20		
Typhoid Inj	Typhim VI				SP	10/30/19		
Zoster	Shingrix				GSK	10/30/19		
Other								

Last Update 9/1/20