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

## Informed Consent Form & Patient Record

Today's Date: _____ Name: _____

Address: _____

Phone: _____ Birth date: _____

Medicare ID Number (Including ALPHA): _____

| Temp Check (max safe temp 100.4) Cell# | Yes | No |
|---|---|---|
| 1. Are you sick today? | | |
| 2. Do you have allergies to medications, food, or any vaccine? (If yes, please list below) | | |
| 3. Have you ever had a serious reaction after receiving a vaccination? | | |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | | |
| 5. Do you have cancer leukemia, AIDS, or any other immune system problem? | | |
| 6. Do you take cortisone, prednisone, or other nervous system problem? | | |
| 7. Have you had a seizure, brain, or other nervous system problem? | | |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? | | |
| 9. Have you received any vaccinations in the past 4 weeks? | | |
| 10. **For women:** Are you pregnant or is there a chance you could become pregnant during the next month? | | |
| 11. Who is your primary care physician? | | |

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 150 Maple Avenue West, Vienna, VA 22180

Vaccine: _____ Lot#: _____ Mfr: _____

VIS Date: _____ Site _____Arm Date VIS Given: _____
Please wait in pharmacy for 15 minutes after the shot has been administered so we can monitor you for any adverse reactions.

Last Updated 9/1/20

RX LABEL HERE

# Notification of Vaccination Letter

Dear Doctor: _____ Fax #: _____

We have recently provided vaccination services to one of your patients. A personal immunization record card was filled out and given to the patient. We want to make certain that you have this information so that you can update your patient's medical record. Please contact us if you have any questions about this information.

Patient's name: _____ Patient's birthdate: _____

The vaccines that were given on _____ are checked below.

*Date*

| **Vaccine** | | |
|---|---|---|
| ___ **Human papillomavirus (HPV) (Gardasil-9)** | | |
| ___ **HepA-HepB (Twinrix)** | | |
| ___ **Hepatitis A (Havrix)** | | |
| ___ **Hepatitis B (Engerix B)** | | |
| ___ **Influenza (injectable)** | | |
| ___ **Meningococcal Polysaccharide (ACWY) (Menactra; Menveo)** | | |
| ___ **Meningococcal Group B Vaccine (Trumenba; Bexsero)** | | |
| ___ **MMR (MMR II)** | | |
| ___ **Pneumococcal polysaccharide (PPSV23) (Pneumovax 23)** | | |
| ___ **Pneumococcal 13-Valent (PCV13) (Prevnar)** | | |
| ___ **Shingles (Shingrix)** | | |
| ___ **Tdap-Tetanus/Diptheria/Pertussis (Boostrix) (Adacel)** | | |
| ___ **Tetanus-diphtheria (Adult, Td) Decavac** | | |
| ___ **Typhoid Injection** | | |
| ___ **Other _____** | | |
| **Name of clinic providing services:** | **Address** | **City, State,Zip** |
| | **150 Maple Ave W** | **Vienna, VA 22180** |
| **Vienna Drug Center** | **Email address** | **Phone number** |
| | **Viennadrug@aol.com** | **703.938.7111** |
| | **Fax** | |
| | **703.938.5242** | |
| | | |

**Updated 9/1/20**

# COVID-19 and Vaccinations

The pharmacy team at Vienna Drug Center is committed to safe vaccination, while also following social distancing guidelines. Therefore, we have launched some new procedures:

- Temperature checks before receiving a vaccine
- Curbside vaccination for high risk individuals on ****Tuesdays and Thursdays between 11 am- 4 pm****
- Having customers wait in their vehicles until called, to prevent crowding in the pharmacy area.

**As always, we appreciate your understanding and patronage as we navigate these changes.**