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Vaccine Informed Consent and Questionnaire Form

Today's Date: _____ Name: _____

Address: _____

Phone: _____ Birth date: _____

Medicare ID Number (Including ALPHA): _____

	Yes	No
1. Are you sick today?		
2. Do you have allergies to medications, food, or any vaccine? (If yes, please list below) Allergies:_____		
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 steroid medication?		
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. For women: Are you pregnant or is there a chance you could become pregnant during the next month?		
10. Have you received any vaccinations in the past 4 weeks?		
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 Signature/ Administrator of Vaccine

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.

Updated 9-1-19