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: _____

Cell#: _____ Birth date: _____

Medicare ID Number (Including ALPHA): _____

Temp Check _____ (max safe temp 100.4)	Yes	No
1. Are you sick today? (All)		
2. Do you have allergies to medications, food, a vaccine component, or latex? (All) (If yes, please list)		
3. Have you ever had a serious reaction after receiving a vaccination? (All)		
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? (MMR/ LAIV)		
5. Do you have cancer leukemia, HIV/AIDS, or any other immune system problem? (MMR/ LAIV)		
6. In the past 3 months have you taken cortisone, prednisone, or any other medications that affect your immune system? (MMR/ LAIV)		
7. In the last 6 weeks, have you had a seizure, brain, or other nervous system problem like Guillian-Barre syndrome? (Flu/Td/Tdap)		
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? (MMR)		
9. Have you received any vaccinations in the past 4 weeks? (MMR/ LAIV)		
10. **For women:** Are you pregnant or is there a chance you could become pregnant during the next month? (HPV/IPV/MenB/MMR/LAIV)		
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 of Administer

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)**
___ **Tetanus-diphtheria (Adult, Td) Decavac**
___ **Typhoid Injection**
___ **Other _____**

Name of clinic providing services:	**Address**	**City, State,Zip**
Vienna Drug Center	**150 Maple Ave W**	**Vienna, VA 22180**
	Email address	**Phone number**
	Viennadrug@aol.com	**703.938.7111**
	Fax	
	703.938.5242	

Updated 9/1/20

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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 (High Dose, IM, 65+)	FLUAD 65+ 2020-2021				Seqirus	8/15/19		
Influenza (Quadrivalent, IM, age 6 mos and older) Influenza (Quad;age 5 & older)	Afluria QUAD 2020-2021				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)	Adacel **(11y-64y)**				SP	04/01/20		
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								