Northside Pharmacies
AN AFFILIATE OF GENESIS HEALTHCARE SYSTEM

2018-2019 VACCINE ADMINISTRATION CONSENT FORM

SECTION A: PATIENT INFORMATION

First Name	MI	Last Name	Birthdate
Address			Age
City	State	Zip	Phone #
Family Doctor	Weight if under 130 lbs (For Needle/Epipen Determination)		Gender M / F

SECTION B: VACCINE

I would like to receive the following vaccine(s):

- ❒ Flu
- ❒ Pneumonia
- ❒ Shingrix (Shingles) ❒ Zostavax (Shingles)
- ❒ MMR (Measles, Mumps, & Rubella)
- ❒ Tdap (Tetanus, Diphtheria, & Pertussis-whooping cough)
- ❒ Td (Tetanus & Diphtheria)

As an adult, have you ever received the following vaccines:

- ❒ Pneumonia If yes, date(s) given_____
- ❒ Shingrix (Shingles) If yes, date(s) given_____
- ❒ Zostavax (Shingles) If yes, date given_____
- ❒ MMR (Measles, Mumps, & Rubella) If yes, date(s) given_____
- ❒ Tdap or Td If yes, date(s) given_____

Has your doctor recommended this (or these) vaccination(s)?.....❒ Yes ❒ No If so, which Doctor:

SECTION C: SCREENING QUESTIONS

1. Are you sick today?.....❒ Yes ❒ No
2. Have you ever had a serious reaction after receiving a vaccination?.....❒ Yes ❒ No
   If yes, please list vaccine and reaction:_____
3. Do you have an allergy to any foods, medications, animals, or vaccine ingredients (e.g. eggs, latex, polymyxin, neomycin, kanamycin, barium, thimerosal, phenol, yeast, gelatin, formaldehyde, etc.)?....❒ Yes ❒ No
   If yes, please list allergy:_____
4. Have you ever had Guillain Barré Syndrome (a type of temporary severe muscle weakness), seizures, brain disorder, or neurological problems?.....❒ Yes ❒ No
5. Have you received any vaccine within the last 28 days?.....❒ Yes ❒ No
   If yes, please list vaccine and date: _____
6. Do you have a condition that may weaken your immune system (e.g. cancer, transplant, HIV/AIDS, tuberculosis, etc.)?.....❒ Yes ❒ No
7. In the past 3 months, have you taken any medications that may affect your immune system (e.g. chemotherapy, radiation treatments, steroids, methotrexate, azathioprine, 6-mercaptopurine, any other treatments for autoimmune diseases, or antivirals, etc.)?.....❒ Yes ❒ No
   If yes, please list medication and dosage_____
8. In the past year, have you received a blood transfusion, blood products, or been given a medication called immune (gamma) globulin?.....❒ Yes ❒ No
9. Do you have a history of thrombocytopenia (a condition that causes you to have an abnormally low number of platelets in your blood)?.....❒ Yes ❒ No
10. Do you have a specific condition that requires you to receive a vaccine in a specific arm?.....❒ Yes ❒ No
11. <u>For Women</u>: Are you pregnant, breastfeeding, or considering becoming pregnant within the next 3 months?.....❒ Yes ❒ No

SECTION D: PNEUMONIA VACCINE ONLY

Complete for Pneumonia Vaccine only.

Skip if age 65 or older.

Please check all conditions that apply

❒ Cigarette smoker ❒ Heart disease (e.g. congestive heart failure, cardiomyopathy) ❒ Lung disease (e.g. COPD, emphysema, asthma) ❒ Diabetes (excluding gestational diabetes) ❒ Liver disease ❒ Alcoholism	A single dose of Pneumovax 23 may be indicated once before age 65 if any of these conditions apply.
❒ Cerebrospinal fluid leak ❒ Candidate for or recipient of cochlear implant	A single dose each of Pneumovax 23 and Prevnar 13 may be indicated once before age 65 if any of these conditions apply. (Pharmacist see schedule)
❒ Asplenia (e.g. sickle cell disease, splenectomy) ❒ Have a condition that affects immune system*** ❒ Taking medications that affect immune system*** ❒ Kidney disease (e.g. chronic renal failure) ❒ Organ or bone marrow transplant	Two doses of Pneumovax 23 (5 years apart) and one dose of Prevnar 13 may be indicated before 65 if any of these conditions apply. (Pharmacist see schedule) ***Conditions:** hematologic and solid tumors, HIV, congenital or acquired immunodeficiency, etc.*** ***Medications:** chemotherapy, radiation, immunosuppressive medications, including long-term systemic corticosteroids, etc.***

SECTION E: CONSENT

I hereby give my consent to the eligible healthcare provider at Northside Pharmacy, to administer the vaccine(s) that I have requested. I have read or had explained to me the CDC's most current Vaccine Information Statement for the elected vaccine(s), and understand the risks and benefits associated. I understand that with all vaccinations there is a possibility of a complication or adverse reaction. I hereby fully hold harmless and release Northside Pharmacy, its affiliates, director, and all employees from any and all liabilities which may arise from the administration of the requested vaccine. In addition, I acknowledge that I have had the opportunity to ask questions and that my questions were answered to my satisfaction. I understand that my information will remain confidential, but may be shared with state immunization registries or the State Health Division. I understand that this information will not be released except as permitted or required by law. I authorize Northside to submit a claim with respect to the above services, to Medicare, Medicaid, or any other contracted third party. I agree to be financially responsible for any copays, deductibles, or denied claims.

Following vaccine administration, I acknowledge that I need to remain near the vaccination location for approximately 15-20 minutes for observation.

→Patient Signature:_____Date:_____

(Parent/Legal Guardian Signature if patient is under age 18)

SECTION F: FOR PHARMACY USE ONLY

Vaccine	Vaccine Name	Lot Number	Manufacturer	Expiration Date	Dosage	Route/Injection Site	Date of VIS
Influenza					**0.5mL**	**IM L / R Deltoid**	
Pneumococcal PPSV23					**0.5mL**	**IM L / R Deltoid** **SQ L / R Arm**	
Pneumococcal PCV13					**0.5mL**	**IM L / R Deltoid**	
MMR					**0.5mL**	**SQ L / R Arm**	
Shingrix					**0.5mL**	**IM L / R Deltoid**	
Tdap					**0.5mL**	**IM L / R Deltoid**	
Td					**0.5mL**	**IM L / R Deltoid**	
Zostavax					0.65mL	SQ L / R Arm	

If sterile diluent/adjuvant is used, please list Lot Number/Manufacturer/Expiration Date_____

Signature & Title of Vaccine Administrator: _____Date: _____