VOHS PHARMACY VACCINE CONSENT FORM

Name:_____

Phone number:_____

DOB:_____ Age:_____ Circle: Male or Female

Address:_____

Dr. Name:_____

Dr. phone number:_____

Flu Shot:_____ Flu Shot HD:_____ Shingrix:_____ Prevnar13:_____ Pneumovax23: _____

	YES	NO
1. Do you feel sick today?		
2. Do you have allergies to any food, medications or vaccinations? If yes, please list. _____ _____		
3. Have you ever had a serious reaction after a vaccination?		
4. Have you received any vaccinations in the past 4 weeks? If yes, please list. _____ _____		
5. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or any other nervous system condition?		
6. Are you 65 years or older?		
7. Do you have diabetes, smoke, have asthma/COPD or congestive heart failure?		
8. If you answered YES to questions 6 & 7, have you ever gotten a pneumonia vaccine?		
9. For women: Are you pregnant or considering becoming pregnant in the next month?		

I certify that I am the patient and at least 18yrs of age or the parent or legal guardian of the patient. I hereby give my consent to the health care provider of Vohs Pharmacy, Inc to administer vaccines above. I understand the risks and benefits associated with the above vaccine(s). I understand that it is not possible to predict all possible side effects or complication associated with receiving vaccines. I authorize Vohs Pharmacy to release any medical or other information to my health care professionals or third party payors as necessary to effectuate care or payment.

Signature:_____Date:_____

Immunizer:	PharmD/Intern

Vaccine	Lot#	Exp Date	Manufacturer	Dosage	Site of Injection	VIS Date
Influenza						
Shingrix						
Prevnar13						
Pneumovax23						