Hart and Dilatush Pharmacy
Informed Consent and Release for Vaccinations
Patients Ages 13 and Up

Vaccine(s) Requested:

Patient Name:_____ Date of Birth_____ Age_____
Address:_____ Phone:_____
Primary Care Physician:_____ Phone:_____

Screening Checklist

Please answer each question. If a question is not clear, please talk with the pharmacist. If you answer "Yes" to any question, it doesn't necessarily mean you should not be vaccinated. It just means additional information will be clarified.	YES	NO	Don't Know
1. Are you sick today?			
2. Do you have any allergies to medications, food, vaccine component or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Do you have heart or lung disease, asthma, kidney disease, diabetes, anemia or other blood disorder?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?			
6. In the past 3 months, have you taken medications that weaken your immune system such as prednisone, cortisone, others steroids, or anticancer drugs, or radiation treatments?			
7. Have you had a seizure or brain or other nervous system problems?			
8. During the past year, have you received a transfusion of blood, blood products, immune (gamma) globulin or antivirals?			
9. Women: Are you pregnant, or is there a chance you could become pregnant in the next month?			
10. Have you received any vaccinations in the past 4 weeks?			

I understand the benefits and risks of the requested vaccinations and I have received a copy of the Vaccine Information Sheet. Hart & Dilatush has answered all of my questions about the vaccine to my satisfaction. I request and consent that the vaccination be given to myself, or the person named above-a minor for whom I am authorized to sign this Consent and Release. I understand I am also giving Hart & Dilatush permission to release any medical or other information necessary to my physician, insurance, or immunization registry, and Hart & Dilatush may process my insurance claim. I release Hart & Dilatush and their employees from any claims that may arise in connection with the vaccination such as negligence or in terms of manufacturer quality.

Signed:_____ Date:_____ Relation to Patient:_____

BELOW FOR PHARMACY USE ONLY

Patient Identity Verified ☐ Screening Checklist Reviewed ☐ Vaccine/Drug Verified ☐

Vaccine	Lot #	Exp. Date	Manufacturer	Dose	Route/Site	Time	VIS Date

Signature of Pharmacist:_____ Date:_____ Date VIS provided:_____

PLACE PRESCRIPTION STICKER ON BACK **FILE WITH PRESCRIPTION HARDCOPIES** **KEEP FOR 10 YEARS**