MEDICINE SHOPPE PHARMACY 2021-2022 VACCINATION CONSENT FORM
PATIENT INFORMATION: (Please fill in the blanks as legibly as possible, circle answers, sign, and date)

(Legal) First Name: ____________________ **MI:** ____ **Last Name:** _______________________ **DOB:**____/_____/_____ **Gender:** ☐ Male ☐ Female

Phone #: ________________________ **Street Address:** ____

P.O. Box ________ **Apt. No.** ___________ **City:** _____________________________________ **State:** ____________ **Zip Code:** ______

Race *(circle one)*: Black/African American   Native Hawaiian/Other Pacific Islander   Native American /Alaska Native   Asian   White   Other

Ethnicity *(circle one)*: Hispanic/Latino   Non-Hispanic/Latino

Vaccination Needed: ☐ FLU ☐ COVID-19 ☐ PNEUMONIA ☐ T-DAP ☐ SHINGRIX ☐ HEP B ☐ HPV ☐ OTHER: ______________

	CIRCLE ONE:	
Have you had any vaccinations within the last 28 days?	YES	NO
Do you have a fever and/or feel sick today? Are you currently being quarantined or treated for an active infection or illness?	YES	NO
Do you have any allergies to medications, vaccination components, (ex: Polyethylene glycol (PEG), Gelatin, Neomycin) foods or latex?	YES	NO
Have you ever had an immediate severe reaction to a vaccination or injectable medication? Reaction would have occurred within the first 4 hours following vaccination and required EpiPen use, hospital treatment, swelling in the face, mouth or throat, fast heartbeat, full body rash, or dizziness.	YES	NO
Do you have any long-term health conditions such as heart disease, diabetes, lung or kidney disease, anemia or other blood disorders, cancer, AIDS, Or any other moderate to severe immune compromising condition? Have a history of seizure, brain, or nervous system concerns?	YES	NO
Are you using any steroid treatments, (prednisone, cortisone, etc.) anticancer medications, or undergoing radiation treatment or chemotherapy?	YES	NO
Within the past year have you received a blood transfusion or any type of blood products? Do you take blood thinners?	YES	NO
Are you pregnant, breastfeeding or planning on becoming pregnant within the next 3 months? If pregnant, how far along? _______________weeks	YES	NO
FOR FLU VACCINATION: If you are 65 years of age or older, would you like to receive the high dose flu vaccination?	YES	NO
FOR COVID-19 VACCINATION: Have you received Monoclonal Antibodies or convalescent plasma as part of COVID-19 treatment?	YES	NO
FOR COVID-19 VACCINATION: Have you already received a dose of the COVID-19 vaccination? ☐ YES ☐ NO **If yes, which vaccine did you receive?** ☐ PFIZER ☐ MODERNA ☐ JANSSEN ☐ OTHER: _____________ **How many doses have you received?** ☐ ONE ☐ TWO ☐ THREE **Date(s) received: 1ST Dose** _______/_______/_______ **2ND Dose** _______/______/_______ **3RD Dose** ______/______/______		
FOR OTHER VACCINATIONS REQUIRING MULTIPLE DOSES: Have you already received a dose of the vaccination? ☐ YES ☐ NO **If yes, which vaccine did you receive?** ☐ PNEUMONIA ☐ SHINGRIX ☐ HEP B ☐ HPV ☐ OTHER: _____________ **How many doses have you received?** ☐ ONE ☐ TWO ☐ THREE **Date(s) received: 1ST Dose** _______/_______/_______ **2ND Dose** _______/______/_______ **3RD Dose** ______/______/______		

RELEASE, ASSIGNMENT, AND INSURANCE AUTHORIZATION: I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine, or the Vaccine Information Sheet (VIS) and I am aware of the risks and benefits. I give consent to this provider/staff for the individual named above to be vaccinated with the vaccination indicated. I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice. I understand that information about this vaccination will be included in (WebIZ) Arkansas Immunization Information System. I authorize the release of any medical information necessary to process my insurance claim(s) and request payment of medical benefits directly to this vaccination Provider. I agree that the authorization will cover all medical services rendered until I revoke the authorization. I agree that the photocopy of this form may be used instead of the original. I have received a Well Child Visit brochure if the patient is age 17 or under and is getting a COVID vaccination. I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.

X Signature of Patient/Parent/Guardian____**DATE**_______________

VACCINE ADMINISTRATION ***(Completed by staff only)***

VACCINE ADMINISTERED (*CIRCLE ONE*):	FLU	COVID-19	PNEUMONIA	T-DAP	SHINGRIX HEP B HPV OTHER: _________
Route	**Site Code**	**Dosage (mL)**	**Brand (ie: Boostrix)**	**Lot Number**	**Expiration Date**
☐ IM ☐ SUB-Q					

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Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: ____ **Date Vaccine Administered:** _________/_________/_________