VACCINATION CONSENT FORM

Immunization Location: ____**Good Day Pharmacy – STORE #:**_____Date:_____

Patient Name: _____D.O.B:_____ Age: _____ Gender: Male_____ Female_____

Address:_____City/State/Zip:_____/_____/_____ Phone:(_____)_____

Primary Care Physician: _____Phone: (_____)_____

Address:_____City/State/Zip:_____/_____/_____

Medicare Part B Number (if applicable):_____ Medicaid Number (if applicable)_____

Before getting a vaccination please *check* YES or NO to the following questions:	Yes	No	Don't know
1. Do you have any cold/ flu/ COVID symptoms today? (Fever, cough, body aches, fatigue) If YES, please postpone your flu vaccine until you feel better.	☐	☐	☐
2. Are you allergic to medications, food, or any vaccines? (Examples: Eggs, Bovine Protein, Gelatin, Latex, Gentamicin, Polymyxin, Phenol, or Thimerosal) **If yes, please list the allergies:**	☐	☐	☐
3. Have you had a serious reaction to a vaccine?	☐	☐	☐
4. Do you have a chronic condition or long-term health problem? **Please check all that apply** Anemia ☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease ☐ Other:_____	☐	☐	☐
5. Have you ever had a neurological disorder, or have you been diagnosed with Guilain-Barre' Syndrome?	☐	☐	☐
6. Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐
7. Have you received any vaccinations in the past 4 weeks? **If yes, please list the vaccination:**	☐	☐	☐
8. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	☐	☐	☐
9. Have you taken prednisone, corticosteroids or anticancer medication or received radiation treatment in the past 3 months?	☐	☐	☐
10. Have you received a blood transfusion or been given immune globulin or antiviral medications in the past year?	☐	☐	☐

I am providing this consent form to GOOD DAY PHARMACY in order that I may be given the vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the vaccination. I hereby acknowledge that, based on the information presented to me, I am eligible to receive the vaccine on this date. I am feeling well today and I have not recently had a fever. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I hereby acknowledge that I have been offered a copy of the GOOD DAY PHARMACY, Notice of Privacy Practices. I release GOOD DAY PHARMACY, its employees, representatives and agents from any liability for giving me this vaccination. I agree to indemnify, defend and hold GOOD DAY PHARMACY harmless from any claim. I accept responsibility for seeking medical attention for any problems associated with my receiving this vaccination. I have had the opportunity to have my questions answered. I understand that by signing below I am responsible for payment of this vaccination if my insurance company denies payment to GOOD DAY PHARMACY.

Patient Signature:_____ **Date**:_____

****For Good Day Pharmacy use only****

VIS Provided: (Please Circle or prove the version of VIS given) Influenza 8/15/19, (PPSV) 10/30/19, (PCV13) 10/31/19, Zoster Recomb 10/30/19, Tdap 4/1/20 Hep A 7/28/20, Hep B 8/15/19, Typhoid 10/30/19 Other_____ Version _____ Date Provided:_____

Immunizer Name (Pharmacist): _____Immunizer Signature:_____
Date Of Admin:_____

Vaccine Administered	Lot#	Exp Date	Manufacturer	Dosage	Circle Site of Injection- if not circled shot was administered in Right Arm	Date PNL Sent
Inactivated Influenza Quad				0.5ml	L / R Deltoid IM	
Fluzone HD				0.7ml	L / R Deltoid IM	
Fluad HD				0.5ml	L / R Deltoid IM	
Pneumococcal Polysaccharide				0.5ml	L / R Deltoid IM	
Shingrix				0.5ml	L / R Deltoid IM	
Tdap (Boostrix or Adacel)				0.5ml	L / R Deltoid IM	
Other:						
Other:						