IMMUNIZATION CONSENT FORM

MEDICAP PHARMACY
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Please check the appropriate boxes for the vaccines you would like to receive.

☐ **Influenza (____Quadrivalent ____High Dose** 65 y/o)
Yearly for anyone over the age of 6 months

☐ **COVID19 ____Moderna (Spikevax)**
Yearly for anyone over the age of 12 updated 10/1/2023

☐ **Other immunizations available at PHARMACY: Tetanus** every 10 years for anyone 18 and older **RSV** All adults over 60 years **Shingles (Shingrix)** All adults 50 years and older **Pneumonia** Adults 65 and older or 18+ with corresponding risk factors

Please fill out this patient information section to the best of your ability.

Patient's Full Name:_____ Date of Birth:_____ Physician:_____

Address:_____ City:_____ State:_____ ZIP:_____

Phone:_____ Email:_____ Preferred Method Contact (Circle): Call - Text - Email

Please answer by placing an "X" in the correct box to the right. If questions, please ask the pharmacist.	**Yes**	**No**
1. Does the patient have allergies to medications, food, latex, or a vaccine component such as eggs or gelatin?		
2. Has the patient had a serious reaction to a vaccine in the past?		
3. Is the patient to be vaccinated currently sick or experiencing a high fever?		
4. Has the patient had a seizure or a neurologic problem (e.g. Guillian-Barré Syndrome)?		
5. Does the patient have a weakened immune system due to cancer, leukemia, HIV/AIDS, or medications such as steroids (e.g. prednisone), or immunotherapy (e.g. treatment for rheumatoid arthritis)?		
6. For **COVID19 ONLY** Vaccinations, has it been at least 3 months since you tested positive for a COVID19 infection?		
Please continue if you are the parent/guardian completing this form for a child (less than 18 years old).	**Yes**	**No**
7. Has your child ever received a vaccination before today?		
8. Has your child ever been diagnosed with wheezing, asthma, or other breathing problems in the past 12 months?		
9. Has a healthcare provider ever stated your child should not receive a vaccine due to some other risk factor?		

Please provide us with a copy of your insurance card, read the waiver, sign, and date below.

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Iowa Immunization Registry for myself or on behalf of the person named below.

_____ _____
Signature of Patient or Parent/Guardian Date

Thank you for choosing us! We truly appreciate your business and we promise to always make time for you! God bless!

Pharmacy use only **Fax to PCP? No Yes → Faxed By: on / /**

Vaccine #1: _____ **MFR**:_____ **Lot #**: _____ **EXP**: _____ **Dose**: 0.25, 0.3, 0.5, 0.7, 1 mL

Site: R L Arm Thigh **Route**: IM SQ Nasal **Administered by**: _____ **Date**: _____

Vaccine #2: _____ **MFR**:_____ **Lot #**: _____ **EXP**: _____ **Dose**: 0.25, 0.3, 0.5, 0.7, 1 mL

Site: R L Arm Thigh **Route**: IM SQ Nasal **Administered by**: _____ **Date**: _____