IMMUNIZATION CONSENT FORM

Last Name	First	Middle	Date of Birth	Gender

Address	City	State	Zip Code

Phone	Primary Care Provider	Social Security #

Please answer all questions:	YES	NO
1. Are you sick today? If yes, ask these additional questions. i. Do you have a new fever? ii. Do you have a cough? iii. Do you have diarrhea? iv. Have you been vomiting?	[ ]	[ ]
2. Have you ever fainted or felt dizzy after receiving a vaccine?	[ ]	[ ]
3. Have you ever had a reaction after receiving a vaccine?	[ ]	[ ]
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder?	[ ]	[ ]
5. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	[ ]	[ ]
6. Do you have allergies to latex, medications, food or vaccines? (Examples : eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)	[ ]	[ ]
7. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome, or other nervous system problems?	[ ]	[ ]
8. For Women, Are you pregnant or considering becoming pregnant in the next month?	[ ]	[ ]
9. Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi Aria, Xelianz, Orencia, Arava, Actermra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	[ ]	[ ]
10. Have you received any vaccinations or skin tests in the past four weeks?	[ ]	[ ]
11. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	[ ]	[ ]
12. Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than 2 weeks?	[ ]	[ ]

I have read or have had explained to me, the Vaccine Information Statement for the vaccine. I understand the risks and benefits, and have had an opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of receiving the vaccine and give consent for the pharmacist at Family Pharmacy to administer the vaccine and communicate the administration to my primary care practitioner (listed above). I acknowledge receiving the pharmacy's Notice of HIPPA privacy practices.

X_____ _____

Signature (Vaccine recipient or representative authorized to make the request **Date**

Please Provide Your Insurance or Medicare Card to Our Staff

********** **PHARMACY USE ONLY** **********

Vaccine _____Manufacturer/NDC _____ VIS date _____

Lot # _____Exp Date_____

Method IM SITE : Left Arm Right Arm

SIGNATURE OF PHARMACIST ADMINSTERING INJECTION: _____ DATE VACCINATED: _____

James Watts SC: 6388; Brandi Johnson SC:12608; Tracie Mims SC:9641; Emily Russell SC:37662; Jess Baughman SC: 36754