Medicine Shoppe Pharmacy Vaccine Administration Consent Form

Name:_____ Date of Birth:_____
Age:_____ Gender: ___M __ F Allergies:_____
Address:_____City:_____State:_____Zip:_____
Phone:_____ Emergency Contact/Number:_____
Physician:_____ Primary Insurance:_____ Cardholder name:_____
Insurance#/Medicare ID#: _____

The following questions will help us to determine which vaccines may be given to you today. Please check the appropriate answer. If any question is not clear, please ask us to explain it.

	YES	NO
1. Are you sick today or do you currently have a fever or infection?	_____	_____
2. Do you have allergies to medications, eggs, thimerosal, vaccines, or any vaccine component?	_____	_____
3. Have you ever had a serious reaction after receiving a vaccination?	_____	_____
4. **If you are over the age of 65**: Have you ever had a pneumococcal vaccination?	_____	_____
5. **If you are over the age of 60**: Have you ever had an RSV vaccination?	_____	_____
6. **If you are over the age of 50**: Have you ever had a Shingles vaccination?	_____	_____
7. **For women**: Are you pregnant or are you planning on becoming pregnant?	_____	_____
8. Do you or any person you live with or take care of have cancer, leukemia, AIDS or any immune system problem?	_____	_____
9. Do you use cortisone, prednisone, steroids, anticancer drugs or have you had X-ray treatments recently?	_____	_____
10. Have you ever had Guillain-Barre Syndrome?	_____	_____
11. During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	_____	_____

I certify that I am at least 18 years old and hereby give my consent to the staff of Medicine Shoppe Pharmacy to administer the vaccine(s) listed below. I have read, or have had read to me, the information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assigns hereby agree to release, indemnify, and hold harmless Medicine Shoppe Pharmacy, it's agents, officers, directors, contractors and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed below.
I AGREE TO WAIT NEAR THE VACCINATION LOCATION FOR APPROXIMATELY 20 MINUTES FOR OBSERVATION BY THE PHARMACIST.

Signature_____ **Date**_____

Vaccine & MFG	Lot # & Exp Date	Dose	Site

Signature of Pharmacist who administered vaccine(s):_____ **Date:**_____