The Medicine Shoppe Pharmacy & Bellevue Home Medical Pharmacy
234 W. Main St., Bellevue, OH 44811 419-483-3784

Vaccine Administration Consent Form

First Name: _____ MI: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____ Ethnicity: please check one ____ Non-Hispanic ____Hispanic

Race: please circle White Indian Asian African American Hawaiian/Pacific Islander

Home Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____ Phone Number: _____

Primary Care Physician: _____ Address: _____

Please check the vaccine(s) you would like to receive today:

___Influenza ___Pneumococcal ___Shingles (zoster) ___COVID-19 ___COVID-19 Booster

---

If you wish to receive the COVID-19 vaccine today, have you ever received a dose of COVID-19 vaccine?

____Yes ___No **If No, which would you like? ___Pfizer ___Janssen (J&J) ___Moderna ___Novavax

If yes, which product: ___Pfizer ___Moderna ___Janssen (Johnson & Johnson) ___Novavax

If yes, will this be your _____Second Dose _____Third Dose (immunocompromised) _____Booster

Date of last dose: _____

If a Booster dose, which would you like today?

_____Pfizer Bivalent (12+) _____Moderna Bivalent (18+) _____Pfizer Monovalent (5-12)

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS). I request the vaccine(s) be given.

***Signature:** _____ **Date:** _____*

To be filled in by Pharmacy:

Vaccine	*Date Admin*	*Lot*	*Exp. Date*	*Dosage (IM)*	*Injection Site*
Flulaval Quad (GSK) Fluad Quad (Seqirus Inc.) (65+)		9249L 346362	6/30/23 5/20/23	0.5ml	L Arm R Arm
Prevnar 13 (Wyeth) Prevnar 20 (Wyeth) Vaxneuvance 15 (Merck) Pneumovax 23 Merck)				0.5ml	L Arm R Arm
Shingrix (GSK)				0.5ml	L Arm R Arm
COVID-19 Initial Series: Novavax (12+) Pfizer (12+) Moderna (12+) Janssen (18+) Pfizer Ped (5-11)				0.2ml 0.25ml 0.3ml 0.5ml	L Arm R Arm
COVID-19 Booster: Moderna Bivalent (18+) Pfizer Bivalent (12+) Pfizer Ped (5-11)				0.2ml 0.25ml 0.3ml 0.5ml	L Arm R Arm

Pharmacist Signature: _____ Date: _____

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason that we should not give you or your child a vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

General Screening Questions	**Yes**	**No**
1. Do you feel sick today?		
2. Do you have any health conditions such as heart disease, diabetes, or asthma? If yes, please list:		
3.Do you have allergies to latex, medications, food, or vaccines (ex-eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, or thimerosal? If yes, please list:		
4. Have you ever had a reaction (allergic or otherwise) after receiving an immunization, including fainting or feeling dizzy?		
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that can cause paralysis) or other nervous system problem?		
6. Do you have a condition that may weaken your immune system (ex-cancer, leukemia, lymphoma, HIV/AIDS or transplant)?		
7. For women: Are you pregnant or considering becoming pregnant in the next month?		
COVID-19 Screening Questions		
8. Have you ever had an allergic reaction to a component of a COVID-19 vaccine, including either of the following: -Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures. -Polysorbate, which is found in some vaccines, film-coated tablets and intravenous steroids -A previous dose of COVID-19 vaccine (This includes a severe allergic reaction, such as anaphylaxis, that required treatment with epinephrine, or that caused you to go to the hospital. It also includes an allergic reaction that caused hives, swelling or respiratory distress, including wheezing.)	**Yes**	**No**
9. Check ALL that apply to you: ___ Am a female between ages 18-49 years old ___ Am a male between ages 12-29 years old ___ Have a history of myocarditis ___ Have a severe allergic reaction to something other than a vaccine such as food, medicine, environmental ___ Had COVID-19 & was treated with monoclonal antibodies or convalescent serum in last 90 days ___ Diagnosed with multisystem inflammatory syndrome after a COVID-19 infection ___ Have a weakened immune system (HIV, cancer, immunosuppressive drugs ___ Have a bleeding disorder ___ Take a blood thinner ___ Have a history of heparin-induced thrombocytopenia ___ Am currently pregnant or breastfeeding ___ Have received dermal fillers ___ History of Guillain-Barre Syndrome (GBS)		

Insurance Information (If not already provided): Type of Insurance _____Pharmacy _____Medicare A&B

ID#_____ Social Security #_____

RX BIN#_____ RX PCN_____ RX Group#_____