Vaccine Consent and Administration Record
Immunization Program

Section A:: Information about patient receiving vaccination (Please print):

Last Name	*First Name*	*Middle Init.*	*Date of Birth*	*Age*	*Sex M / F*
Street		*City*	*State*	*Zip*	
Phone			*Allergies*		
Primary care Physician (PCP)		*PCP Phone Number*			

Section B:: The following questions will help us determine your eligibility to be vaccinated today.

Which vaccines are you requesting to have administered today? Please check all requested vaccines: _____*Flu Shot,*_____*Pneumonia,*_____ *Shingles,*_____*Tetanus/Diphtheria/Pertussis* _____*Meningitis* _____ *RSV* _____*Other*	*YES*	*NO*	*DON'T KNOW*
1. Do you feel sick today?			
2. Do you have allergies to medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal) If yes, please list the allergies:			
3. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list the vaccination.			
4. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?			
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 causes paralysis) or other nervous system problem?			
6. Are you 65 years of age or older?			
7. Do you smoke?			
8. Do you have a chronic condition or long-term health problem? If yes, please check all that apply. ____Anemia, ___ Asthma, ___ Diabetes, ____Heart disease, ___ Kidney disease, ___ Liver disease, ____ Lung disease,____ Other			
9. If you answered YES to question #6, 7 or 8, have you ever had a pneumonia vaccination?			
10. Have you ever had a shingles vaccination (for patients 60 years of age and older only)?			
11. Are you a healthcare worker?			
12. For women: Are you pregnant or considering becoming pregnant in the next month?			
13. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatments?			
14. 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?			
15. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?			

Section C

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of St Jesus Pharmacy as applicable, to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless St. Jesus Pharmacy Corp. Pharmacy Inc D/B/A St Jesus pharmacy, as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: I understand the purposes/benefits of my state's immunization registry ("State Registry"). I acknowledge that, depending upon my state law, I may prevent, by using a state-approved opt-out form ("Opt-Out Form"): (a) disclosure of my immunization information to the State Registry; or (b) the State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry. St. Jesus Pharmacy Corp. D/B/A St Jesus pharmacy, as applicable, will, if my state permits, provide me with an Opt-Out Form. Unless I provide St. Jesus Pharmacy Corp. D/B/A St Jesus pharmacy, as applicable, with a signed Opt-Out Form, I elect to participate fully in, and consent to St. Jesus Pharmacy Corp. D/B/A St Jesus pharmacy, as applicable, reporting my immunization information to the State Registry. I authorize St. Jesus Pharmacy Corp. D/B/A St Jesus pharmacy, as applicable, to (1) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (2) submit a claim to my insurer for the above requested items and services, and (3) request payment of authorized benefits be made on my behalf to St. Jesus Pharmacy Corp. D/B/A St Jesus pharmacy, as applicable, with respect to the above requested items and services. I further agree to be fully financially responsible for any cosharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if St. Jesus Pharmacy Corp. D/B/A St Jesus pharmacy invoices me after the time of service, upon receipt of such invoice

*Patient Signature (Parent or Guardian, if minor):*_____ *D a t e:*_____

Section D (HEALTH CARE PROVIDERS ONLY) The following section is to be completed by the health care provider only.

*Immunizer Name (print):*_____ *Immunizer Signature:* _____ *RPh/PharmD Administration Date:* _____*Date VIS given to Patient:* _____

Vaccine	*Lot#*	*Exp Date*	*Manufacturer*	*Dosage*	*Circle site of Injection*	*VIS Date*	*Rph Initial*
				0.5 ML	*L/R Deltoid* **IM**		
					L/R Deltoid *IM*		