TLC MEDICAL CENTRE
Pharmacy · Medical Equipment

VACCINE CONSENT & ASSESSMENT

First Name:	MI:	Last Name:	
Home Phone:	Date of Birth:	Gender:	
Home Address:	City:	State:	Zip:
Primary Care Provider:	Provider Address:	Provider Phone:	

I WANT TO BE PROTECTED FROM THE FOLLOWING *(PLEASE CHECK ALL THAT APPLY):*

☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HPV ☐ *MEASLES/MUMPS/RUBELLA(MMR)** ☐ MENINGITIS PNEUMONIA
☐ *SHINGLES** ☐ TETANUS, DIPHTHERIA, +/- PERTUSSIS ☐ *VARICELLA** ☐ OTHER (*PLEASE SPECIFY*): _____

	Please answer the following questions so we can assess the safety and appropriateness of vaccination:	**Yes**	**No**
ALL VACCINES	1. Are you sick today? ☐ New fever ☐ Cough ☐ Diarrhea ☐ 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, Guillan-Barre syndrome or other nervous system problems?		
	8. **For Women:** Are you currently pregnant, breastfeeding, or are you planning on becoming pregnant within the next month?		
***LIVE VACCINES**	1. Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actermra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?		
	2 Have you received any vaccinations or skin tests in the past four weeks?		
	3. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?		
	4. Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?		

I hereby give my consent to the health care provider of TLC, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless TLC, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors and employees from any liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries, and will remain confidential and will not be released except as permitted or required by law. If eligible, I have received a copy of the TLC Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after the administration for observation by the administering healthcare provider.

X _____ Date: _____

(SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT IS UNDER 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

(For Pharmacy Use Only) *The following section is to be completed by the pharmacy:*

Vaccine Name: _____	Vaccine Name: _____	Vaccine Name: _____
Manufacturer: _____	Manufacturer: _____	Manufacturer: _____
Dose: _____	Dose: _____	Dose: _____
Vaccine Lot#: _____	Vaccine Lot#: _____	Vaccine Lot#: _____
Vaccine Exp. Date: _____	Vaccine Exp. Date: _____	Vaccine Exp. Date: _____
Diluent Lot #/Exp. Date: _____	Diluent Lot #/Exp. Date: _____	Diluent Lot #/Exp. Date: _____
Injection Site: **LEFT ARM** **RIGHT ARM**	**Injection Site:** **LEFT ARM** **RIGHT ARM**	**Injection Site:** **LEFT ARM** **RIGHT ARM**
Route: **IM** **SubQ**	**Route:** **IM** **SubQ**	**Route:** **IM** **SubQ**
Immunizer: _____ RPh/Intern	Immunizer: _____ RPh/Intern	Immunizer: _____ RPh/Intern
Supervising RPh/Lic#: _____	Supervising RPh/Lic#: _____	Supervising RPh/Lic#: _____
Date Administered/VIS Given: ___/___/____	Date Administered/VIS Given: ___/___/____	Date Administered/VIS Given: ___/___/____
VIS Version Given: ___/___/____	VIS Version Given: ___/___/____	VIS Version Given: ___/___/____

Date of FAX Transmission: _____

Initials of RPh/Tech _____

Notice of Immunization

Dear Healthcare Provider:

We have recently provided vaccination services to one of your patients. A personal immunization record card was filled out and given to the patient. We want to make certain that you also have this information so that you can update your patient's medical record. Please contact us if you have any questions about this information.

Vaccinee's name:
Vaccinee's Date of Birth:

The Vaccination that was given on _____ is listed below

Vaccine given: _____

Dose: _____

Method: IM / SQ

Location: Right / Left Arm

Lot #: _____

Manufacturer: _____

Exp. Date: _____

_____
Administering Pharmacist or Pharmacy Intern

_____
Pharmacist Supervising Administering Pharmacy Intern (If applicable)

_____
Contact Information for Adminstering or Supervising Pharmacist

TLC
190 Crepe Myrtle Drive
Aiken, SC 29803
803-648-7800