Vaccine Administration Consent Form

CardinalHealth™

Section A (Please print clearly.)

First name: Last name:

Age: Date of birth: Gender (check one): ☐ Female ☐ Male ☐ Non-binary

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander Ethnicity: ☐ Hispanic ☐ non-Hispanic

Home address:

City: State: ZIP Code:

Email address: Phone number:

Primary care physician name: Physician phone: Physician fax:

☐ Seasonal Influenza	☐ Hepatitis B	☐ Tetanus/TDap
☐ COVID-19	☐ HPV	☐ Meningococcal
☐ Hepatitis A	☐ Pneumococcal	☐ MMR
☐ Chicken pox (varicella)	☐ Shingles (zoster)	☐ Other

Section B (The following questions will help us determine your eligibility for vaccination today.)

All vaccines	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 (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? **If yes, please list:**	☐	☐
4. Have you ever had a reaction 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 causes paralysis) or other nervous system problem?	☐	☐
6. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	☐	☐
7. For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐

Live vaccines (e.g., Chicken pox, FluMist, MMR, typhoid, shingles)	Yes	No
8. Have you received any vaccinations or skin tests in the past four weeks? **If yes, please list:**	☐	☐
9. Are you currently on home infusions, weekly injections such as Humira™ (adalimumab), Remicade™ (infliximab) or Enbrel™ (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐	☐
10. Are you currently taking high-dose steroid therapy (prednisone > 20 mg/day or equivalent) for longer than two 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 any antibiotics, antiviral or antimalarial medications? (Typhoid only)	☐	☐
13. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐	☐
14. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	☐	☐
15. Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?	☐	☐

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Section B (continued)

COVID-19	Yes	No
16. Have you ever received a dose of COVID-19 vaccine? If yes, which product? ☐ Pfizer ☐ Moderna ☐ Janssen (Johson & Johnson) ☐ Another product _____ If yes, will this be your ☐ 2nd dose or ☐ 3rd dose Date of last dose:	☐	☐
17. Have you ever had an allergic reaction to: (This includes a severe allergic reaction, such as anaphylaxis, that required treatment with epinephrine or EpiPen™, or that caused you to go to the hospital. It also includes an allergic reaction that caused hives, swelling or respiratory distress, including wheezing.)	☐	☐
• 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		
18. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐	☐

19. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (e.g., HIV, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Section C (Consent and Release)

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of person to receive vaccine and VIS: Date:

(or parent/guardian, if recipient is younger than 18 years)

Insurance information and authorization:

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the immunizations and receive payment.

Medicare patients:	Red, White, and Blue card No.:		Pharmacy insurance:	
Plan name:	Member No.	BIN No.	PCN No.	Group No.

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Section C (continued)

Vaccine	Route	Dosage	NDC No.	Mfg	Lot No.	Exp. date	Site of admin	Guardian name (minor)	Guardian relationship (minor)	VIS pub date	Dose No. (if applicable)
COVID-19	IM	mL					☑L ☐R				
Influenza	ID	0.5 mL					☐L ☐R				
Shingrix	IM	0.5 mL					☐L ☐R				
PCV13	IM	0.5 mL					☐L ☐R				
PPSV23	IM	0.5 mL					☐L ☐R				
Hepatitis A	IM	0.5 – 1.0 mL					☐L ☐R				
Hepatitis B	IM	0.5 – 1.0 mL					☐L ☐R				
HPV	IM	0.5 mL					☐L ☐R				
Japanese Enceph	IM	0.5 mL					☐L ☐R				
Meningococcal	IM	0.5 mL					☐L ☐R				
MMR	SQ	0.5 mL					☐L ☐R				
Rabies	IM	1.0 mL					☐L ☐R				
Td	IM	0.5 mL					☐L ☐R				
Tdap	IM	0.5 mL					☐L ☐R				
Typhoid	IM	0.5 mL					☐L ☐R				
Varicella	SQ	0.5 mL					☐L ☐R				
Other:											

Immunizer name (print): **Immunizer signature:**