Vaccine Administration Consent Form

Section A (Please print clearly.)

First Name: _____ Last Name: _____

Age: _____Date of birth: _____Gender (check one): ☐Female ☐Male ☐non-binary

Home address: _____

City: _____ State: _____ZIP Code: _____

Phone number: _____

Primary care physician name: _____Physician phone: _____

SEASONAL INFLUENZA **PNEUMOCOCCAL** **RSV** **SHINGRIX** **COVID**

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

		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?			
8	Have you ever had an allergic reaction to another vaccine (including COVID-19 vaccine) or an injectable medication?			
9	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 COVID or any other Vaccine?			
10	**HAVE YOU EVER RECEIVED COVID VACCINE ?** ☐ **YES** ☐ **NO** **(If Yes Which Product?** _____ **Date of Last Dose :** _____			
11	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. ☐ 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) ☐ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection			

Live Vaccines (e.g., Chickenpox**, Flumist, MMR, Typhoid, shingles)**		**YES**	**NO**	**N/A**
12	Have you received any vaccinations or skin tests in the past four weeks? If yes, please list:			
13	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?			
14	Are you currently taking high-dose steroid therapy (prednisone > 20 mg/day or equivalent) for longer than two weeks?			
15	Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?			
16	Are you currently taking any antibiotics, antiviral or antimalarial medications? (Typhoid only)			
17	Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)			
18	Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)			
19	Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?			

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.
Insurance plan name: OR ☐ Insurance info on file at Pharmacy
Member/recipient ID #
RX Bin #
RX PCN #
RX Group #

For Pharmacy Only:

Place Pharmacy Label Here:

Vaccine**: INFLUENZA/ RSV / PNEUMOCOCCAL/SHINGRIX/ COVID** (NDC #_____
Route: **IM** / Dosage: ____ / Mfg.:_____
Guardian Name (Minor): (Lot # _____
VIS Pub. Date : _____
Dose No:_____ (Exp Dt.: _____

Site of Admin: LD / RD

Immunizer Name (Print): _____ Immunizer Signature: _____