Jolley's Pharmacy

Medication & Compounding Specialists

"If it's not available...let us make it for you"

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Patient History and Consent Form

Name_____ D.O.B._____ Phone #_____
Address_____City_____State_____Zip_____
Race_____Ethinicity_____Date_____
Insurance: BIN_____ PCN_____ ID_____ RX Group_____

	Yes	No
1. Have you ever had a severe reaction to any vaccine?	____	____
2. Have you had a live vaccine in the past 4 weeks(MMR, Varicella, Flu mist)	____	____
3. Have you had a COVID vaccine, if so which one_____, Dose #___	____	____
4. Are you allergic to eggs, bakers yeast, Streptomycin or Neomycin, PEG?	____	____
5. Do you have a fever, diarrhea or vomiting today?	____	____
6. Do you or anyone in your home have any form of immunosuppression? (Cancer, HIV / AIDS or any disease that affects the immune system)	____	____
7. Have you had any blood or blood products in the past year?	____	____
8. Are you pregnant, or planning on pregnancy in the next 3 months?	____	____
9. Are there any unresolved health concerns we need to be aware of?	____	____

I have read, or have had read to me, the information regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked below: I authorize the pharmacy to bill and receive payment for these immunizations.

Influenza_____ lot #_____ manufacture _____
xp.date_____ injection site_____ R or L
Other_____ lot #_____ manufacture _____
exp.date_____ injection site_____ R or L
COVID_____ lot #_____ manufacture _____
Shot # 1,2,3 exp.date_____ injection site_____ R or L

Signature of patient or guardian_____

Vaccine administrator signature_____