IMMUNIZATION CONSENT FORM

MEDICAP PHARMACY
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Please check the appropriate boxes for the vaccines you would like to receive.

- **Influenza (____Quadrivalent ____High Dose** 65 y/o) Yearly for anyone over the age of 12 updated 10/1/2023
  Yearly for anyone over the age of 6 months
- € **COVID19 ____Moderna (Spikevax)**
- **Other:**_________________________ **Tetanus** every 10 years for anyone 18 and older **Shingles (Shingrix)** Recommended for all adults 50 years and older **Pneumonia** Adults 65 and older or 18+ with corresponding risk factors

Please fill out this patient information section to the best of your ability.

Patient's Full Name:____ Date of Birth:_______________ Physician:________________

Address:____ City:_______________________ State:_____ ZIP:__________

Phone:_____________________ Email:________________________________ Preferred Method Contact (Circle): Call - Text - Email

Please answer by placing an "X" in the correct box to the right. If questions, please ask the pharmacist.	**Yes**	**No**
1. Does the patient have allergies to medications, food, latex, or a vaccine component such as eggs or gelatin?		
2. Has the patient had a serious reaction to a vaccine in the past?		
3. Is the patient to be vaccinated currently sick or experiencing a high fever?		
4. Has the patient had a seizure or a neurologic problem (e.g. Guillian-Barré Syndrome)?		
5. Does the patient have a weakened immune system due to cancer, leukemia, HIV/AIDS, or medications such as steroids (e.g. prednisone), or immunotherapy (e.g. treatment for rheumatoid arthritis)?		
6. For **COVID19 ONLY** Vaccinations, has it been at least 3 months since you tested positive for a COVID19 infection?		
Please continue if you are the parent/guardian completing this form for a child (less than 18 years old).	**Yes**	**No**
7. Has your child ever received a vaccination before today?		
8. Has your child ever been diagnosed with wheezing, asthma, or other breathing problems in the past 12 months?		
9. Has a healthcare provider ever stated your child should not receive a vaccine due to some other risk factor?		

Please provide us with a copy of your insurance card, read the waiver, sign, and date below.

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Iowa Immunization Registry for myself or on behalf of the person named below.

____ ____________________

Signature of Patient or Parent/Guardian Date

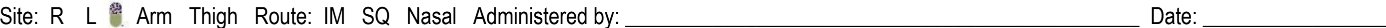
Thank you for choosing Medicap! We truly appreciate your business and we promise to always make time for you!

Pharmacy use only Fax to PCP? No Yes ☐ Faxed By: on / /

Vaccine #1: ____________________ MFR:__________________ Lot #: ______________ EXP: ______________ Dose: 0.25, 0.3, 0.5, 0.7, 1 mL

Site: R L Arm Thigh Route: IM SQ Nasal Administered by: ____ Date: ________________

Vaccine #2: ________________________ MFR:______________________ Lot #: ________________ EXP: ________________ Dose: 0.25, 0.3, 0.5, 0.7, 1 mL



Site: R L Arm Thigh Route: IM SQ Nasal Administered by: ____ Date: _________________