

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: _____

<input type="checkbox"/> Seasonal Influenza	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Tetanus/TDap
<input type="checkbox"/> COVID-19	<input type="checkbox"/> HPV	<input type="checkbox"/> Meningococcal
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> MMR
<input type="checkbox"/> Chicken pox (varicella)	<input type="checkbox"/> Shingles (zoster)	<input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any health conditions such as heart disease, diabetes or asthma? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
7. For women: Are you pregnant or considering becoming pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you currently taking high-dose steroid therapy (prednisone > 20 mg/day or equivalent) for longer than two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you currently taking any antibiotics, antiviral or antimalarial medications? (Typhoid only)	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?	<input type="checkbox"/>	<input type="checkbox"/>

Vaccine Administration Consent Form



Section B (continued)

COVID-19	Yes	No
16. Have you ever received a dose of COVID-19 vaccine? If yes, which product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product _____ If yes, will this be your <input type="checkbox"/> 2nd dose or <input type="checkbox"/> 3rd dose Date of last dose:	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>
19. Check all that apply to you: <input type="checkbox"/> Am a female between ages 18 and 49 years old <input type="checkbox"/> Am a male between ages 12 and 29 years old <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection <input type="checkbox"/> Have a weakened immune system (e.g., HIV, cancer) or take immunosuppressive drugs or therapies <input type="checkbox"/> Have a bleeding disorder <input type="checkbox"/> Take a blood thinner <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have received dermal fillers <input type="checkbox"/> 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.

Please complete, print, and bring it to your appointment

Vaccine Administration Consent Form



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					<input type="checkbox"/> L <input type="checkbox"/> R				
Influenza	ID	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Shingrix	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
PCV13	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
PPSV23	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Hepatitis A	IM	0.5 – 1.0 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Hepatitis B	IM	0.5 – 1.0 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
HPV	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Japanese Enceph	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Meningococcal	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
MMR	SQ	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Rabies	IM	1.0 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Td	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Tdap	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Typhoid	IM	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Varicella	SQ	0.5 mL					<input type="checkbox"/> L <input type="checkbox"/> R				
Other:											

Immunizer name (print):

Immunizer signature:

Please complete, print, and bring it to your appointment