

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot. It is recommended that I stay on location for 15 minutes following any injections.

I have read the adverse reactions associated with the administration of vaccines. A copy of the vaccine manufacturer’s drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person name below for whom I am the legal guardian (“Ward”). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Health Depot and its affiliates, subsidiaries, divisions, directors, contractors agents and employees (collectively “Released Parties”) , from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Health Depot, nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Health Depot will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and /or your Ward’s personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices.

SIGNATURE AND DATE (REVIEW INFORMATION ON ADVERSE REACTIONS ON REVERSE)

Signature/Legal Guardian	Printed Name	Date
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ADMINISTRATIVE RECORD (For pharmacy staff use only)

Date of Vaccination/Date VIS Given

Health Depot Pharmacies

Location: Fort Smith Barling Greenwood

Phamacist/Prescriber Signature

OFFSITE LOCATION

Vaccine: _____ Site of Inj. _____
 Lot No.: _____ Exp Date: _____
 Rt of Admin: _____ MFR: _____
 VIS Version: _____ Dosage: _____

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