VACCINE QUESTIONNAIRE AND CONSENT FORM

LEWISVILLE DRUG
PHARMACY & WELLNESS CENTER

PATIENT INFORMATION

Fulll Name: _____ Date of Birth: _____

Email: _____ Phone: _____ Gender: ☐ Male ☐ Female

Address: _____ City/State: _____ Zip Code: _____

Mother's Maiden Name: _____ Age: _____ Race: _____

Doctor's Name: _____ Doctor' Phone: _____

INSURANCE INFORMATION:

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the immunizations and receive payment.

Insurer: _____ Subscriber ID: _____

Bin #: _____ PCN: _____ Group #: _____

PLEASE RESPOND DAY OF VACCINE	YES	NO	N/A
Do you feel sick today?			
Do you have any allergies to medications, foods (i.e. eggs), latex, or a vaccine component (i.e. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.). **If yes, please list:** _____			
Have you ever had an allergic reaction to another vaccine or an injectable medication? *			
Do you have long-term health problems, such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease, anemia or other blood disorder? **If yes, please specify:** _____			
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
Have you ever been diagnosed with rheumatoid arthritis, ankylosing spondylitis, or Chron's disease?			
In the past three months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steriods, anticancer drugs, and/or have had radiation treatments?			
Have you had a seizure, a brain or nervous system disorder or Guillian Barre Syndrome?			
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
Has any physician or healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?			
Have you received any vaccinations within the past four weeks?			
FOR WOMEN: Are you pregnant or considering becoming pregnant in the next 30 days?			
FOR TETANUS: Do you have an open wound, puncture, or tissue tear that prompted you to get a tetanus shot?			

CONSENT: I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Lewisville Drug Company, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Lewisville Drug Company to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist.

Signature: _____ Name (print): _____ Date: _____

If guarantor/guardian, indicate your relationship to the recipient: _____

PHARMACIST USE ONLY

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Injection Site	Date of VIS	Signature
Influenza								
Pneumococcal								
Herpes Zoster								
Hepatitis B								
Meningococcal								
Tetanus - Diphtheria								
Tetanus, Diphtheria Toxoids & Acellular Pertussis								