IRIS ☐ Flu_____ Tdap_____ RX #_____

Daniel Pharmacy-Informed Consent to Receive Vaccines for Adolescents (0-18 years)

Name:_____ Date of Birth:_____Male/Female

Mother's Maiden Name (First and Last-used for immunization registry purposes):_____

Street:_____ Physician:_____

City:_____ Zip Code:_____ Physician Phone: (_____)_____

Phone: (_____)_____ Physician Address:_____

☐ Private Insurance ☐ Cash $ Amount:_____ ID #:_____

For parents or guardians: Answer yes or no to the following questions. If any are unclear, ask for assistance.

	YES	NO
1. Is the child sick today?		
2. Does the child have allergies to medications, food, a vaccine component, or latex?		
3. Has the child had a serious reaction to a vaccination in the past?		
4. Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?		
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?		
6. If your child is a baby, have you ever been told that he/she has had intussusception?		
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?		
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?		
10. In the past year, has the child received a transfusion of blood products, or been given immune (gamma) globulin or an antiviral drug?		
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?		
12. Has the child received vaccinations in the past 4 weeks?		

I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of vaccine(s) requested. I authorize this information to be forwarded to my primary care physician, authorizing physician or local Dept. of Health if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Daniel Pharmacy, its employees and agents; from any and all liability that might arise from this vaccination on behalf of myself, my heirs and personal representatives.

Parent/Guardian Signature:_____ **Date:**_____

Please initial that you have received our Notice of Privacy Practice for HIPAA_____(initials)

_____ _____ _____ _____ _____
Vaccine Lot # Exp. Date Manufacturer Dose (mL)

☐Left arm ☐Right arm ☐Nasal ☐IM ☐SC Admin. Date_____VIS Date_____

_____ _____ _____ _____ _____
Vaccine Lot # Exp. Date Manufacturer Dose (mL)

☐Left arm ☐Right arm ☐Nasal ☐IM ☐SC Admin. Date_____VIS Date_____

Administrator_____ Daniel Pharmacy, 1114 Central Ave. Fort Dodge, IA 50501