UPTOWN DRUG AND HOME MEDICAL

CONSENT AND RELEASE - INJECTABLE VACCINATIONS

Vaccine(s) Requested: Injection Site: LD RD

_____ ____/____/____ (____) ☐ M ☐ F
LAST NAME OF PATIENT FIRST MIDDLE DATE OF BIRTH AGE

_____ (____)_____-_____
PERMANENT ADDRESS CITY STATE ZIP PRIMARY PHONE

_____ _____ _____ _____
PRIMARY INSURANCE INSURANCE ID # OR MEDICARE B # (INCLUDE NIMBERS AND LETTERS) PRIMARY PHYSICIAN PHYSICIAN FAX#

I confirm that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I request and consent that the vaccination be given, as I direct Uptown Drug, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Uptown Drug permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Uptown Drug to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Uptown Drug and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Uptown Drug in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

CHECK ALL THAT APPLY: ☐ I authorize vaccine administration by an immunization trained student pharmacist
☐ I acknowledge I have been advised to remain in area for 15min. for observation but choose to decline.
☐ I acknowledge I have been counseled about potential side effects, when and where to receive treatment.

X_____ _____ _____
SIGNATURE OF PERSON TO RECEIVE VACCINE(S)/ PARENT OR GAURDIAN DATE PRINTED NAME OR GAURDIAN / PHONE#

Please complete the questions below for yourself or the person receiving the vaccine.

YES	NO	DON'TKNOW	
			Are you currently sick with a fever?
			Have you ever had a life-threatening allergy to any component (or part) of ANY vaccine? If yes, please describe:
			Have you ever received a dose of COVID-19 vaccine?
			Do you have a seizure disorder or a brain disorder?
			Have you ever had a pneumonia shot?
			Are you currently pregnant?
			Do you have a bleeding disorder or are you taking a blood thinner?
			Have you ever had a severe life-threatening allergy to eggs or egg products?
			Do you have cancer, leukemia, HIV, active shingles, a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?
			Have you received a blood transfusion, received immune gamma globulin or had radiation therapy?
			Have you received any other vaccinations within the last 4 weeks?
			Have you taken an antiviral medication for the flu within the last 48 hours?
			Have you received a passive antibody therapy as treatment for COVID-19?

BELOW LINE PHARMACY ONLY

VACCINE	LOT OF VACCINE	EXP. DATE	MANUFACTURER	DOSAGE	INJECTION SITE	TIME	VIS DATE
SEASONAL INFLUENZA				0.5ML	IM L / R DELTOID		8/15/19
HD INFLUENZA (65+)				0.5ML	IM L / R DELTOID		8/15/19
PREVNAR 13			WYETH	0.5ML	IM L / R DELTOID		10/30/19
PNEMOVAX 23			MERCK	0.5ML	IM L / R DELTOID		10/30/19
Tdap			GSK	0.5ML	IM L / R DELTOID		4/1/20
SHINGRIX			GSK	0.5ML	IM L / R DELTOID		10/3/19
Covid-19	1ST / 2ND		MODERNA	0.5ML	IM L / R DELTOID		
Covid-19	1ST / 2ND		PFIZER	0.3ML	IM L / R DELTOID		
Covid-19			JANSEN	0.5ML	IM L / R DELTOID		

SIGNATURE OF PHARMACIST_____RPH _____INTERN/TECH initial DATE VIS PROVIDED TO PT _____

DATE/TIME FAXED TO PCP_____/_____AM / PM COUNSELING ACCEPTED ___ DECLINED ___