

VACCINE CONSENT & ASSESSMENT

First Name:	MI:	Last Name:
Home Phone:	Date of Birth:	Gender:
Home Address:	City:	State: Zip:
Primary Care Provider:	Provider Address:	Provider Phone:

I WANT TO BE PROTECTED FROM THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

- FLU
 HEPATITIS A
 HEPATITIS B
 HPV
 MEASLES/MUMPS/RUBELLA(MMR)*
 MENINGITIS PNEUMONIA
 SHINGLES*
 TETANUS, DIPHTHERIA, +/- PERTUSSIS
 VARICELLA*
 OTHER (PLEASE SPECIFY): _____

Please answer the following questions so we can assess the safety and appropriateness of vaccination:		Yes	No
ALL VACCINES	1. Are you sick today? <input type="checkbox"/> New fever <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting		
	2. Have you ever fainted or felt dizzy after receiving a vaccine?		
	3. Have you ever had a reaction after receiving a vaccine?		
	4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder?		
	5. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?		
	6. Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)		
	7. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome or other nervous system problems?		
	8. For Women: Are you currently pregnant, breastfeeding, or are you planning on becoming pregnant within the next month?		
*LIVE VACCINES	1. Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actemra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?		
	2. Have you received any vaccinations or skin tests in the past four weeks?		
	3. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?		
	4. Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?		

I hereby give my consent to the health care provider of TLC, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless TLC, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors and employees from any liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries, and will remain confidential and will not be released except as permitted or required by law. If eligible, I have received a copy of the TLC Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after the administration for observation by the administering healthcare provider.

X _____ Date: _____
 (SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT IS UNDER 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

(For Pharmacy Use Only) The following section is to be completed by the pharmacy:

Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____
Injection Site: LEFT ARM RIGHT ARM Route: IM SubQ Immunizer: _____ RPh/Intern Supervising RPh/Lic#: _____ Date Administered/VIS Given: ____/____/____ VIS Version Given: ____/____/____	Injection Site: LEFT ARM RIGHT ARM Route: IM SubQ Immunizer: _____ RPh/Intern Supervising RPh/Lic#: _____ Date Administered/VIS Given: ____/____/____ VIS Version Given: ____/____/____	Injection Site: LEFT ARM RIGHT ARM Route: IM SubQ Immunizer: _____ RPh/Intern Supervising RPh/Lic#: _____ Date Administered/VIS Given: ____/____/____ VIS Version Given: ____/____/____