Keeseville Pharmacy & Cornerstone Drug and Gift **Immunization Consent Form**

Name (Please Print)	Date of Birth	Sex	County of Residence
Address	City	State	ZIP
Phone	For Persons Under 19 Years Old, Mother's Maiden Name		
Insurance/ ID#	Doctor's Name		
Clinic/Office Site Where Vaccine Administered:	Doctor's Address		

Screening Checklist for Contraindications

	YES	NO
1. Are you sick today?	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, Metabolic disease (e.g., diabetes, anemia, or other blood disorder?	☐	☐
5. Do you have cancer, leukemia, HIV?AIDS or any other immune system problem?	☐	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, Other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐
7.Have you had a seizure or a brain or other nervous system problem?	☐	☐
8.During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐

Immunization Agreement

1. I understand that the pharmacy advises me to remain within the pharmacy at least 20 minutes after the injections for observation
2. I will notify the pharmacy of any adverse events associated with immunization.
3. Permission is herby granted to Keeseville Pharmacy/ Cornerstone Drug and Gift to release information to my primary care provider, identified above, regarding any vaccinations received today.
4. I agree to be vaccinated today with the following vaccine(s):

Influenza Pneumococcal Meningococcal Herpes Zoster Tdap

NYSIIS Reporting

Our Pharmacy and the New York State Department of Health want to inform you about the Statewide Immunization Information System (IIS). By law, any immunizations given to patients under the age of 19 must be reported into a secure web-based IIS and this electronic system is Called the New York State Immunization Information System (NYSIIS).

For patients aged 19 and older, immunizations may be reported to NYSIIS with patient consent. Inclusion of adults will significantly contribute To a fully-developed, population -based database of accurate immunization records, and complete date is essential to developing statewide immunization programs intended to reduce the burden of vaccine preventable disease.

Patient consent to report to NYSIIS: YES or NO (Circle One) Mother's Maiden Name: __________________

Patient Signature : ____ **Date:** ______________

Area Below to Be Completed by Rph.

________________________________ **Vaccine**

Administration Date ______________________

Administration Site ☐ Left Arm ☐ Right Arm ☐ IM
☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ SQ

Manufacturer & Lot Number ______________________

VIS Date ______________________

Rph Signature ______________________

Next Immunization Due: ☐ Next Year ☐ Other ☐ None

________________________________ **Vaccine**

Administration Date ______________________

Administration Site ☐ Left Arm ☐ Right Arm ☐ IM
☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ SQ

Manufacturer & Lot Number ______________________

VIS Date ______________________

RPh Signature ______________________

Next Immunization Due: ☐ Next Year ☐ Other ☐ None