IMMUNIZATION CONSENT FORM

THE MADISON PHARMACY
66 MAIN STREET • MADISON, NJ 07940
T: 973.377.0075 F: 973.377.1960
www.MadisonPharmacy.com

Patient Name _____ Date of Birth _____ Age _____ Gender ☐ Male ☐ Female

Address _____ City_____ State _____ Zip Code _____

Phone Number _____ Medicare Part B ID Number (if 65yrs or older)_____ _____

Primary Dr. Name _____ Dr. Phone Number_____

Which vaccine(s) would you like to receive today? _____

Medical Conditions: _____ Enter weight if less than 130lbs: _____

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If question is not clear, please ask your healthcare provider to explain it.

1) Are you sick today? Yes ☐ No ☐

2) Do you have allergies to medications, food, a vaccine component, or latex? Yes ☐ No ☐

3) Have you ever had a serious reaction after receiving a vaccination? Yes ☐ No ☐

4) Have you had a seizure or a brain or other nervous system problem? Yes ☐ No ☐

For live viruses ONLY

5) 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? Yes ☐ No ☐

6) Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes ☐ No ☐

7) In the past 3 months, have you taken medication that affect your immune system, such as prednisone, or other steroids, or anticancer drugs: drugs for the treatment of rheumatoid arthritis, Chron's disease, or psoriasis: or have you had radiation treatment? Yes ☐ No ☐

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? Yes ☐ No ☐

9) For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes ☐ No ☐

10) Have you received any vaccinations in the past 4 weeks? Yes ☐ No ☐

I have read the adverse reactions associated with the influenza and pneumococcal vaccine. A copy of the vaccine information sheet was provided. Furthermore, I have also had the opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reaction that may result. My medical record may be shared with my physician/insurance company. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release The Madison Pharmacy, physician, and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). The Madison Pharmacy and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damaged suffered or sustained by any person at any time in connections with or as a result of this vaccine program or the administration of the vaccines described above. The Madison Pharmacy will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

_____ _____

Signature/Legal Guardian Date

_____

Print Name

Notification of Vaccination

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Dear Doctor or nurse at _____
PATIENT'S PRIMARY CARE CLINIC

We recently provided vaccination services to your patient. We want to make certain that you have information about the vaccines administered so you can update your patient's medical record. Please contact us if you have any questions about this information.

Patient's name _____ Patient's birthdate _____ (MM/DD/YR)

(For a child, parent/guardian name _____ Parent/guardian birthdate _____ (MM/DD/YR))

The vaccine we administered on _____ is listed below
DATE

Standing Order Physician : Dr. Zhexiang Li

_____ Vaccine Lot No. _____ Exp Date _____

☐ Right Arm _____ (Pharmacist initials) MFR _____

☐ Left Arm _____ (Pharmacist initials) VIS Version Date _____

Route _____

Informed patient to remain in pharmacy area for 20 minutes after vaccination for observation _____ (initials)

☐ Hepatitis B (Engerix-B; Recombivax HB)
DOSE (circle one): 0.5 mL 1.0mL

☐ Td (age 7 years and older)

☐ Tdap (adult)

Pneumococcal

☐ PCV20 (Prevnar 20 [conjugate])

☐ PPSV23 (Pneumovax 23 [poly-saccharide])

☐ IPV (Polio)

☐ MMR

☐ Varicella (chickenpox) (Varivax)

☐ MMRV (ProQuad)

☐ Hepatitis A (Havrix; Vaqta)
DOSE (circle one): 0.5 mL 1.0 mL

☐ HepA-HepB (Twinrix)

Human papillomavirus (HPV
Circle One: Dose 1 Dose 2 Dose 3

☐ HPV2 (Cervarix)

☐ HPV4 (Gardasil)

☐ HPV 9 (Gardasil 9)

Meningococcal

☐ MenACWY (MCV4)
(Menactra, Menveo [conjugate])

☐ MPSV4 (Menomune [polysaccharide])

☐ MenB (Bexsero, Trumenba [protein])

☐ Influenza
BRAND _____
DOSE: 0.5 mL

☐ Zoster (shingles) (Zostavax)

☐ Shingrix (Shingles)
Circle One: Dose 1 Dose 2

☐ Other _____

Place RX
Label Here

_____
Printed Name of Pharmacist Administering Vaccination / Title

_____ _____
Signature of Pharmacist Administering Vaccination **Date of Administration**