Achorn Pharmacy
289 Post Road East
Westport CT, 06880
Tel: 203-226-0741

Immunization Consent Form

Covid-19 (Pfizer / Moderna)

Influenza/ RSV / Shingrix / Tdap

Pneumonia (Prevnar13, Prevnar20 & Pneumovax 23)

LAST NAME FIRST NAME Birth date Age

ADDRESS CITY STATE ZIP

10-DIGIT PHONE

Primary Physician (Optional)

For the safety of other customers and our employees, let's first get these familiar questions out of the way. Please answer this brief COVID-19 questionnaire for the person being scheduled. All fields are required.

1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID -19? □ Yes □ No

2. In the past two weeks, have you had contact with someone who tested positive for COVID-19? □ Yes □ No

3. Do you currently or have you in the past 14 days, experienced the new onset of a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea? □ Yes □ No

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

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. 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
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems? □ Yes □ No
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 treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or have you had radiation treatments? □ Yes □ No
7. Have you had a seizure or a brain or other nervous system problem? □ 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? □ Yes □ No
10. Have you received any vaccinations in the past 14 Days? □ Yes □ No

Consent and Waiver: I Consent to the staff to administer the medication(s) mentioned below. I have reviewed the Vaccine Information Sheet(s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the standing order physician and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss or damage that may result there from. I acknowledge that **I have reviewed the pharmacy's privacy policies according to HIPPA.** I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any co pay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. I am aware that an immunization certified pharmacist might be administering this medication. I agree to wait near the vaccination area for approximately 10-15 minutes to receive treatment in case of adverse reaction.

SIGNATURE DATE

ADMINISTRATIVE RECORD **FOR PHARMACY USE ONLY**

PHARMACIST SIGNATURE DATE

VACCINE: INFLUENZA / RSV / SHINGRIX / TDAP/ SITE OF INJECTION: Left Arm / Right Arm

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LOT NUMBER & Exp. Date _____

MANUFACTURER:

VIS Date: