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

Immunization Consent Form

Shingrix / Tdap / Influenza

Pnueumonia (Prevnar13 & Pneumovax 23)

LAST NAME FIRST NAME MI Birthdate

ADDRESS CIT STAT ZI

10-DIGIT PHONE

Primary Physician

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 4 weeks? ☐ 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 PRINT

ADMINISTRATIVE RECORD FOR

PHARMACIST SIGNATURE

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

Pnueumonia (Prevnar13 & Pneumovax 23)

LOT NUMBER:_____

EXPIRATION DATE: _____

MANUFACTURER: