CONSENT FORM/VACCINE ADMINISTRATION RECORD

Patrick Square Pharmacy is providing necessary vaccines based on current immunization guidelines by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider. We will provide your provider with records of the vaccine(s) administered through the state immunization registry.

First and Last Name	Date of birth	Age	Gender
Address (Street, City, State)	Primary Care Doctor		
Phone #	**Medication or Food Allergies**		

Consent: ***Please review the statement below confirming your consent for vaccination and provide the information requested*** I have read, or had explained to me, the Vaccine Information Statement for the vaccine(s) I am receiving today. I understand the risks and benefits, and have been provided an opportunity to ask questions. I wish to receive the vaccine(s) and hereby give consent for the pharmacist to administer the vaccine(s) and communicate the administration of the vaccine(s) to my primary care practitioner listed above and to the state immunization registry.

Signature of person receiving vaccine - OR - legal guardian	Today's Date
X	/ /

Which vaccines are you requesting today? **Flu** **Pneumonia (Prevnar-13, Pneumovax-23)** **Shingles** **Tdap** **MMR**

Screening Questions for ALL vaccines:	**YES**	**NO**
Are you sick today, or do you have a fever?		
Have you ever had a serious reaction to a vaccine, such as fainting or anaphylaxis?		
Do you have any allergies to medications, foods, latex, or any vaccine component?		
Do you have any long-term health problems with heart disease, kidney disease, liver disease, nervous system disorders, respiratory disorders (COPD, asthma), blood disorders, or diabetes?		
Do you have a weakened immune system because of HIV/AIDS or another disease affecting the immune system, long-term treatment with high-dose steroids, or cancer treatments?		
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?		
Are you a parent, family member, or caregiver to a newborn infant?		
Have you received a tetanus booster in the past 10 years?		
For WOMEN only: Are you pregnant or considering becoming pregnant in the next month?		

To be completed by the immunizing pharmacist:

Signature of Vaccine Administrator _____ Date given: ____/_____/_____

Name of Vaccine / Dose #	Injection Site	Manufacturer	Lot #	Exp. Date	VIS Date