808 Hwy 378, Ste B
Lexington, SC 29072
(803) 756-3460

# Patient Immunization Consent and Administration Form

***Patient Information:***

Last Name _____ First Name _____ Date of Birth _____

Address _____ City, State, Zip _____ Phone _____

Primary Care Provider (PCP) Name _____ PCP Phone # _____

PCP Address _____ City, State, Zip _____ PCP Fax # _____

☐ **FLU** ☐ **PNEUMOCOCCAL 13 23** ☐ **HEPATITIS A** ☐ **HEPATITIS B**

☐ **TDAP** ☐ **SHINGLES** ☐ **MMR**

| ***Screening Questions:*** | **YES** | **NO** | **DON'T KNOW** |
|---|---|---|---|
| 1 Are you sick today? (For example: a cold, fever, cough, diarrhea, vomiting, or acute illness) | ☐ | ☐ | ☐ |
| 2 Have you ever fainted or felt dizzy after receiving a vaccination? | ☐ | ☐ | ☐ |
| 3 Have you ever had a reaction after receiving a vaccination? | ☐ | ☐ | ☐ |
| 4 Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, phenol, yeast, or thimerosal) List: _____ | ☐ | ☐ | ☐ |
| 5 Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner) | ☐ | ☐ | ☐ |
| 6 Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic, metabolic disease (e.g. diabetes), anemia or other blood disorder? | ☐ | ☐ | ☐ |
| 7 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? | ☐ | ☐ | ☐ |
| 8 For women: Are you pregnant or nursing? Could you become pregnant during the next month? | ☐ | ☐ | ☐ |
| 9 Have you taken any anti-virals (For example: Tamiflu, Valacyclovir) within the past 48 hours? | ☐ | ☐ | ☐ |
| 10 **For Shingrix Only:** Do you have a weakened immune system or in the past 3 months, taken medications that weaken the immune system such as coritisone, prednisone, other steroids, anticancer drugs, or radiation treatments? | ☐ | ☐ | ☐ |

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with re of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well.

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 corresponding vaccine(s) that I am receiving. I understand the risks and benefits and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the corresponding vaccine(s) and hereby give consent to administer the vaccine(s) and communicate the administration of the vaccine(s) to my primary care practitioner, who is listed above. I understand and agree that My Pharmacy may be required by applicable law to report certain information without notice to me about my vaccination to the appropriate state and federal regulatory authorities for purposes such as reporting adverse events or immunization registries.

I further agree to hold harmless **My Pharmacy**, and its officers, employees, agents, representatives, contractors, successors, and assignees from any claim or action arising out of or, in any way incidental to this vaccination. I am 18 years or older, under no duress, and have read and understand this informed consent for the corresponding vaccine(s).

_____

*Print: Name of patient to receive vaccine or person authorized to make the request (parent/guardian)*

**X** _____ **Date:** _____

*Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)*

**PHARMACY USE ONLY:**

***Vaccine Administration Information:*** **RX #:** _____

Administration Date: _____ Vaccine: _____ Manufacturer: _____

Lot #: _____ Exp. Date: _____ Route: _____ Site: _____

Volume (mL): _____ VIS Date: _____ Date VIS Given to Patient: _____

_____ _____

Administering Immunizer Name & Title Administering Immunizer Signature