my PHARMACY & OPTICAL
Where Hospitality Matters

808 HWY 378, STE B
LEXINGTON, SC 29072
(803) 756-3460

PATIENT IMMUNIZATION CONSENT & ADMINISTRATION FORM (VACCINES)

PATIENT INFORMATION:

PT GENDER: ☐ F ☐ M PT SSN: - -

LAST NAME _____ FIRST NAME _____ DOB _____

ADDRESS _____ ROOM ____ CITY, STATE, ZIP _____ PHONE _____

PRIMARY CARE PROVIDER (PCP) _____ PCP PHONE _____ PCP FAX _____

PCP ADDRESS _____ CITY, STATE, ZIP _____

☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ TDAP ☐ SHINGLES ☐ PNEUMONIA 20 ☐ DTaP ☐ RSV
☐ HPV ☐ MENINGITIS ☐ PEDIARIX ☐ OTHER _____

SCREENING QUESTIONS:

		YES	NO	UNSURE
1	Are you sick today? If YES, please circle your answer next to the following questions:	☐	☐	☐
	(A) Do you have a new fever? **YES** **NO**			
	(B) Do you have a cough? **YES** **NO**			
	(C) Do you have diarrhea? **YES** **NO**			
	(D) Have you been vomiting? **YES** **NO**			
2	Have you ever fainted or felt dizzy after receiving a vaccination?	☐	☐	☐
3	Have you ever had any other reaction after receiving a vaccination?	☐	☐	☐
4	Do you have allergies or any reactions to latex, medications, food, or vaccines? *(Example: Eggs, Bovine Protein, Gelatin, Gentamycin, Polymyxin, Neomycin, Phenol, Yeast, or Thimerosal)* LIST THEM HERE:	☐	☐	☐
5	Do you take anticoagulation medication? *(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 any other blood disorder?	☐	☐	☐
7	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain–Barré syndrome (GBS), or any other nervous system problems?	☐	☐	☐
8	Are you currently pregnant or nursing, or could possibly be during the next month?	☐	☐	☐
9	Have you taken any anti-viral medication within the past 48 hours? *(Example: Tamiflu, Valacyclovir)*	☐	☐	☐
10	Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐	☐
11	Do you consider yourself to be, or have you ever been told by a physician you are, immunosuppressed?	☐	☐	☐

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 record of the vaccine(s) administered here so that your medical records may be complete but be prepared to take your personal record with you to your next appointment. 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 with an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the corresponding vaccine - I 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 effects 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 Patient/Parent/Guardian Name

_____ Sign Patient/Parent/Guardian Name

_____ Date

Pharmacy Use Only

Date Administered: _____

RX # _____ Vaccine _____ Volume (mL) _____ Administration Site _____ Route _____

Lot #: _____ Exp. Date _____ Manufacturer _____ VIS Date _____ Date VIS Given to Patient _____

RX # _____ Vaccine _____ Volume (mL) _____ Administration Site _____ Route _____

Lot #: _____ Exp. Date _____ Manufacturer _____ VIS Date _____ Date VIS Given to Patient _____

RX # _____ Vaccine _____ Volume (mL) _____ Administration Site _____ Route _____

Lot #: _____ Exp. Date _____ Manufacturer _____ VIS Date _____ Date VIS Given to Patient _____

_____ Immunizer Name & Title

_____ Immunizer Signature