my PHARMACY & OPTICAL

FACILITY NAME: _____

Consent for Inactivated Vaccine Administration

PATIENT INFORMATION

Name (as it appears on insurance card): _____ Date of Birth: _____ Age: _____

☐ Male ☐ Female Phone: _____ SSN: _____ Medicare ID: _____

Street Address: _____ Room/Unit #: _____ City: _____ State: _____ Zip: _____

Primary Care Provider (PCP): _____ PCP Phone: _____ PCP Office: _____

☐ **High Dose Flu (age 65y+)** ☐ **Regular Flu (age 6m-64y)** ☐ **Shingles** ☐ **RSV** ☐ **Tdap** ☐ **Pneumonia** ☐ **Meningitis** ☐ **HPV** ☐ **DTaP**
☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **Polio** ☐ **COVID (Preference – not guaranteed:** ◯ **Pfizer** ◯ **Moderna** ◯ **Novavax)** ☐ **Other**_____

Screening Questions	YES	NO	UNSURE
1. Are you sick today? If yes, (1) Do you have a new fever? Y/N (2) Do you have a cough? Y/N (3) Do you have diarrhea? Y/N (4) Have you been vomiting? Y/N			
2. Have you ever fainted or felt dizzy after receiving a vaccine?			
3. Have you ever had a reaction after receiving a vaccine?			
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?			
5. 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?			
6. Do you have allergies to latex, medications, food, or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal) If yes, please list: _____			
7. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems?			
8. For women: Are you pregnant or considering becoming pregnant in the next month?			

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).

_____ _____ _____

Patient/Guardian Printed Name **Signature of Patient/Guardian (or name of who received the verbal consent)** **Date of Consent**

Pharmacy Use Only

Vaccine & Manufacturer		Vaccine & Manufacturer		Vaccine & Manufacturer		Vaccine & Manufacturer	
Lot #	**Exp Date**	**Lot #**	**Exp Date**	**Lot #**	**Exp Date**	**Lot #**	**Exp Date**
Volume mL	**Route** IM	**Volume** mL	**Route** IM	**Volume** mL	**Route** IM	**Volume** mL	**Route** IM
Admin Site	**Admin Date/Date VIS Given**	**Admin Site**	**Admin Date/Date VIS Given**	**Admin Site**	**Admin Date/Date VIS Given**	**Admin Site**	**Admin Date/Date VIS Given**

RX Insurance Information:

Insurance Name: _____

RX BIN: _____

RX PCN: _____

Cardholder ID: _____

VIS Dates: Hep A 1/31/25; Hep B 1/31/25; HPV 8/6/21; Flu 1/31/25; Meningitis 1/31/25; PCV 5/29/25; RSV 1/31/25; Tdap 1/31/25; Shingles 2/4/22; COVID 1/31/25

IMMUNIZER NAME: _____ **IMMUNIZER SIGNATURE:** _____ **LIC #:** _____ **Date:** _____