Immunization Consent Form

The following questions will help us determine if the vaccination is appropriate to be given today.

QUESTIONS	YES	NO	UNCERTAIN
ARE YOU SICK TODAY / DO YOU HAVE A FEVER			
DO YOU HAVE ALLERGIES TO MEDICATIONS / FOOD / VACCINES			
HAVE YOU PREVIOUSLY RECEIVED A COVID – 19 VACCINE – IF SO WHICH MANUFACTURER AND WHEN			
HAVE YOU EVER HAD A SERIOUS REACTION AFTER RECEIVING A VACCINATION			
IF YES, WAS IT FROM COVID – 19?			
DO YOU HAVE A BLEEDING DISORDER OR ARE YOU TAKING BLOOD THINNERS			
DO YOU HAVE A SEIZURE, BRAIN DISORDER OR OTHER NERVOUS SYSTEM PROBLEM			
DO YOU HAVE CANCER, LEUKEMIA, AIDS OR ANY OTHER IMMUNE SYSTEM PROBLEM			
DO YOU TAKE CORTISONE, PREDNISONE OR OTHER STEROID OR ANTICANCER DRUGS, OR HAVE YOU RECENTLY RECEIVED X-RAY TREATMENTS			
DURING THE PAST YEAR, HAVE YOU RECEIVED A TRANSFUSION OF BLOOD OR BLOOD PRODUCTS, OR BEEN GIVEN A MEDICINE CALLED IMMUNE GLOBULIN			
FOR WOMEN: ARE YOU PREGNANT OR IS THERE A CHANCE THAT YOU COULD BECOME PREGNANT IN THE NEXT MONTH			
ARE YOU OVER THE AGE OF 16 (PFIZER) OR 18 (MODERNA)			
HAVE YOU RECEIVED ANY VACCINATION IN THE PAST TWO (2) WEEKS			

Consent for Administration of Vaccine:

I have read, or have had read to me, the information regarding the vaccine and have been given a copy of the vaccination information statement. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine. **I understand that I have to remain in the pharmacy for 15 minutes following the vaccine administration.**

Name (Print) _____ **Date of Birth**_____

Signature_____

----------OFFICE USE----------

Date of Vaccination: _____ RX#: _____Administered by:_____

Site of Vaccination: Right Arm Left Arm Dose: 0.3ml 0.5ml

Vaccine Manuf:_____Lot Number_____Expiration Date: _____

FLU 65 FLU SHINGRIX #1 SHINGRIX #2 MODERNA PFIZER TDAP PREVNAR13 PREVNAR20 PNEUMOVAX23 ABRYSVO