VACCINE CONSENT FORM

PART I *Please print clearly*

First Name: | MI: | Last Name: | Age:

Home Phone: | Gender (M/F): | Weight: lbs | Date of Birth: / / | Choose School

Home Address: | City: | State: | ZIP Code:

Primary Care Provider Name (Write N/A if unknown) | Physician/Provider Address (Write N/A if unknown):

I WANT TO BE PROTECTED FROM THE FOLLOWING (***PLEASE CHECK ALL THAT APPLY***)

☐ FLU-INJECTION ☐ *FLU-NASAL** ☐ TETANUS, DIPTHERIA, PERTUSSIS (Tdap) ☐ COVID
☐ HEPATITIS A ☐ HEPATITIS B ☐ HPV ☐ PNEUMONIA ☐ *SHINGLES* ☐ *OTHER:*_____

I WANT THE VACCINE GIVEN IN MY (***PLEASE CHECK ONE***): ☐ LEFT ARM ☐ RIGHT ARM

	PART II Please answer the following questions so we can assess the safety and the appropriateness of vaccination:	Yes	No
ALL VACCINES	1. Do you have a fever, chills, cough, shortness of breath, muscle/body aches, headache, loss of taste/smell, sore throat, diarrhea, nausea/vomit?	☐	☐
	2. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list what you are allergic to:_____	☐	☐
	3. Have you ever had a serious reaction after receiving a vaccine? (Lip swelling, arm swelling, trouble breathing, seizure, etc.)	☐	☐
	4. Have you ever had a dose of the AE vaccine for which you are requesting today? If yes, please list vaccine and date:_____	☐	☐
	5. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?	☐	☐
	6. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:_____	☐	☐
	7. Have you had a mastectomy? **If yes, ☐ Left ☐ Right ☐ Both	☐	☐
	8. **For Women**: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?	☐	☐
*LIVE VACCINES	9. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?	☐	☐
	10. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira, Enbrel) or had radiation treatments? If yes, list medication, dose, and date last taken:_____	☐	☐
	11. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
	12. Do you have a long-term health problem with heart disease, lung disease (e.g. COPD, asthma), kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	☐	☐
	13. **For Children or Teens**: Is the patient receiving long-term aspirin therapy or have a history of wheezing (2-4yo)?	☐	☐
	14. Is the person to be vaccinated currently living with or expected to come in close contact with someone with a severely weakened immune system who must be in protective isolation (e.g. a bone marrow transplant recipient)?	☐	☐

PART III I hereby give my consent to the healthcare provider of the Butterfield's Pharmacy, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless Shriver's Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries, and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Butterfield's Pharmacy to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. **Furthermore, I acknowledge that I have been advised to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering healthcare provider.**

Patient Signature*: Signature at site **Date:** _____ **Submit**

(*or Signature of Legal Guardian if patient is under age 18)

PART IV (For Pharmacy Use Only) *All items in the following section MUST be entirey completed for each Vaccine*

Vaccine Name:	Vaccine Name:	Vaccine Name:
Manufacturer:	Manufacturer:	Manufacturer:
Vaccine Lot #:	Vaccine Lot #:	Vaccine Lot #:
Vaccine Exp. Date:	Vaccine Exp. Date:	Vaccine Exp. Date:
Diluent Lot#/Exp. Date:	Diluent Lot#/Exp. Date:	Diluent Lot#/Exp. Date:
Dose: 0.2mL 0.5mL 0.65mL 1.0mL	Dose: 0.2mL 0.5mL 0.65mL 1.0mL	Dose: 0.2mL 0.5mL 0.65mL 1.0mL
Injection Site: LEFT ARM RIGHT ARM NASAL	**Injection Site: LEFT ARM RIGHT ARM NASAL**	**Injection Site: LEFT ARM RIGHT ARM NASAL**
Route: IM SubQ	**Route: IM SubQ**	**Route: IM SubQ**
Immunizer:_____RPh/Intern	Immunizer:_____RPh/Intern	Immunizer:_____RPh/Intern
Supervising RPh:_____	Supervising RPh:_____	Supervising RPh:_____
Date Administered/VIS Given: / /	Date Administered/VIS Given: / /	Date Administered/VIS Given: / /
VIS Version Date: / /	VIS Version Date: / /	VIS Version Date: / /

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