



INFORMED CONSENT TO RECEIVE VACCINES

First Name _____	MI _____	Last Name _____		M	F	Y	N
Home Phone _____	Date of Birth (mm/dd/yyyy) _____	Age _____	Gender _____	Pregnant? _____			
Home Address _____	City _____	State _____	Zip Code _____				
___ American Indian or Alaskan; ___ Native Hawaiian or Pacific Islander; ___ Asian; ___ Black/African American; ___ White/Caucasian; ___ Hispanic/Latino; ___ Other							

Please answer the following questions:	Yes	No	Unsure
1. Do you have a fever or illness today?	___	___	___
2. Have you experienced in the past 14 days: fever, unusual cough, or unusual shortness of breath?	___	___	___
3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
4. Have you received any vaccinations in the last 14 days? If so, list here: _____	___	___	___
5. Do you have allergies ANY to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gentamicin, polymyxin, neomycin, phenol, PEG (polyethylene glycol), or thimerosal)?	___	___	___
6. Have you ever had a serious reaction to a vaccine in the past?	___	___	___
7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	___	___	___
8. Do you have a chronic condition or long-term health problem? If yes, please check all that apply. ___ Anemia ___ Asthma ___ Diabetes ___ Heart ___ Kidney ___ Liver ___ or Lung disease ___ Other	___	___	___
9. For the past 3 months, have you taken medications that affect your immune system: steroids, anticancer drugs, drugs for rheumatoid arthritis, Crohn's disease, psoriasis, or had radiation treatments?	___	___	___
10. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder?	___	___	___

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the Vaccine Information and had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my primary care physician, State Immunization Registry, or the local Dept. of Health, if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination. I agree that I am responsible for insurance co-pays or the cost of administered vaccines not covered by insurance.

Patient Signature: _____

(Parent or Guardian, if minor)

Date

Vaccine Information (Office use only)					
Vaccine 1	Lot #	Exp. Date	Manufacturer	Dose (ml)	VIS Date
IM or SubQ	Left Arm or Right Arm				
Route	Admin. Site	Admin. Date	Administered by	Title	
Vaccine 2	Lot #	Exp. Date	Manufacturer	Dose (ml)	VIS Date
IM or SubQ	Left Arm or Right Arm				
Route	Admin. Site	Admin. Date	Administered by	Title	
Prescriber Signature		Store Info		Prescription Date	