Vaccine Consent Form

First Name:_____ Middle:_____ Last Name:_____ Date of Birth:_____/___/_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: _____ Primary Care Physician:_____ Vaccine(s) Requested:_____ Occupation: _____

Medicare Part B: Yes/No Medicare ID Number (From Red, White & Blue Card):_____ Sex:☐ M ☐F

Prescription Insurance Card holder ID:_____ BIN_____ PCN_____ Group_____

Weight _____ (if under 18 years of age) Race: ☐ Asian ☐ Black ☐American Indian ☐White ☐ Other SSN: _____

Please answer the following questions to determine if you are eligible for a vaccine. If you have any questions, please ask a pharmacist.

Vaccine Questionnaire		**Yes**	**No**
1	Have you received a dose of COVID-19 vaccine? If yes, which product? ☐ Pfizer ☐ Pediatric Pfizer (5 to <12 years) ☐ Moderna ☐ Johnson & Johnson		
2	**COVID vaccine only**: Is this your ☐ **First Dose** ☐ **Second Dose** ☐ **Third Dose** (Immunocompromised Patients) or ☐ **Booster**		
3	Are you currently sick with a moderate to high fever, vomiting/diarrhea?		
4	Have you ever had a serious reaction after receiving an immunization including feeling dizzy or fainting?		
5	Do you have chronic health conditions such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?		
6	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease?		
7	Do you have allergies to latex, medications, food, or vaccines? (eggs, gelatin, neomycin, polymyxin or thimerosal, polyethylene glycol). If yes, please list: _____		
8	Have you ever had a seizure disorder, brain disorder (including Guillain Barre) or any other nervous system disorders?		
9	In the past 3 months have you taken medications that weaken the immune system such as cortisone, prednisone, other steroids or anticancer drugs, or have you had radiation treatments?		
10	**For Tdap and adult Td (ONLY):** Do you have an open wound, puncture or tissue tear that prompted you to get a tetanus shot?		
11	**For women**: are you pregnant or considering becoming pregnant in the next month?		
Live Vaccines Only			
1	Are you currently on home infusions or weekly injections?		
2	Have you received any vaccines or skin tests in the past four weeks?		
3	Have you received a blood transfusion, blood products, or immune globulin or antiviral drug in the past year?		
4	Do you have a history of thymus disease or thymectomy? (yellow fever only)		
5	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)		

If receiving a booster or additional dose of the COVID-19 vaccine, outside of the primary series, I attest that I meet the current CDC requirements. I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or legal guardian of the minor Patient; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the healthcare provider of pharmacy. I acknowledge that I have received, read, and understand the Vaccine information Statement for the vaccines(s) below. I have had the chance to ask questions about the contents of the Vaccine Information Statement. I understand both the benefits and risks associated with receiving this vaccine and believe the benefits outweigh the risks. I understand and agree that this company may be required by applicable law to report certain information without notice to me about my vaccinations to the appropriate state and federal regulatory authorities for purposed such as reporting of adverse events or immunization registries. I further agree to hold harmless 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 under no duress and have read and understand this informed consent for the vaccine listed below. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one. I also understand that I should wait in store for a 15-minute observation period after receiving my vaccine. Additionally, by signing below I attest that I qualify to receive vaccine based on my state health jurisdictions guidelines/eligibility requirements.

_____ _____ _____

Print Name Signature of Patient or Legal Guardian Date

Admin Date	Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Site of Injection	EUA Date	VIS Date	Date MD Notified

For children ages 3-17: I attest I informed the patient or adult caregiver of the importance of pediatrician wellness checks ☐

Signature of administering Pharmacist: