

# Immunization Consent Form

## PATIENT INFORMATION

PATIENT'S LAST NAME		PATIENT'S FIRST NAME		MI	GENDER (M/F)	BIRTH DATE (MM/DD/YYYY)	
ADDRESS			CITY	STATE	ZIP	10-DIGIT PHONE NUMBER	
PRIMARY CARE PROVIDER (MD, DO, NP, PA)					PROVIDER PHONE NUMBER		
RACE				ETHNICITY			

## INSURANCE INFORMATION

CASH	MEDICARE #	INSURANCE CARRIER NAME	GROUP #	ID #
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## VACCINE(S) REQUESTED

Influenza injectable	Meningococcal	Hepatitis A & B	Varicella (Chickenpox)	Whooping Cough (Tdap, DTaP)
Influenza nasal	Hepatitis A	HPV	Shingles 1st dose	Measles Mumps & Rubella (MMR)
Pneumococcal	Hepatitis b	Polio	Shingles 2nd dose	Tetanus (Td)
Other			Other	

## PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

1. Are you sick today?	Yes	No	8. Do you have a history of Guillain-Barre Syndrome?	Yes	No
2. Do you have allergies to medications, food or vaccines? Allergies _____	Yes	No	9. Have you had a seizure, brain or nerve problem?	Yes	No
3. Have you ever had a serious reaction after receiving an immunization?	Yes	No	10. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	Yes	No
4. Have you ever fainted or felt dizzy after receiving an immunization?	Yes	No	11. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
5. Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	Yes	No	12. Have you received any vaccinations in the past 4 weeks? If yes, what vaccines? _____	Yes	No
6. Are you currently being treated for Cancer, leukemia, AIDS or any other immune system problem?	Yes	No	13. Are you allergic to eggs?	Yes	No
7. Are you currently taking cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments?	Yes	No	14. Are you allergic to latex?	Yes	No

## ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

## AUTHORIZATION

Medicare Part B patients authorize the release of any medical or other information to process this claim and request payment of government benefits to either themselves or the party who accepts the assignment below. If the patient's insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.

I have read or have read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Monroe Pharmacy, its affiliates, their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Signature of Patient/Caregiver \_\_\_\_\_ Full Name of Guardian (if patient is under 19) \_\_\_\_\_ Date \_\_\_\_\_

## DATE OF VACCINATION

## PHARMACIST / PRESCRIBER SIGNATURE

Vaccine (Lot # & Exp. Date)	Site of Injection
Vaccine: _____ Lot #: _____ Exp: _____	
Vaccine: _____ Lot #: _____ Exp: _____	
Vaccine: _____ Lot #: _____ Exp: _____	

