VACCINE CONSENT FORM

First Name:	Last Name:		
Phone Number:	Date of Birth: / /	Age:	Gender:
Home Address:	City:	State:	Zip Code:
Primary Doctor:			

I WANT TO BE PROTECTED FROM THE FOLLOWING (*please circle all that apply*):

Flu Hepatitis A Hepatitis B HPV Measles/mumps, rubella (MMR) Meningitis Pneumonia Shingles TDAP Varicella COVID RSV

	Please answer the following questions so we can decide if the vaccine is appropriate:	Yes	No
ALL VACCINES	1. Have you had a physical exam by a doctor in the last year?		
	2. Do you have a fever or feel sick today?		
	3. Do you have any allergies to medications, foods (i.e. eggs), latex, or a vaccine component? (gelatin, neomycin, polymxin, yeast, thimerosal, etc.) If yes, please list what your allergy: _____		
	4. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	5. Have you had the vaccine(s) you are receiving today before?		
	6. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorders?		
	7. Have you received in vaccines in the past 28 days? If yes, please list vaccine and date: _____		
	8. **For Women**: Are you currently pregnant, breast feeding 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 problems?		
	10. In the past 3 months, have you had medication that weakens your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis, or radiation treatment? If yes, please 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 globulin or an antiviral drug? If yes, please list medication, dose and date last taken: _____		

I give my consent to the healthcare provider of Whitaker Pharmacy, its affiliates and subsidiaries, 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) for the vaccine(s) I have elected to receive. I have had the opportunity to ask questions there were answered to my satisfaction. I understand that the information contained on this form may be shared with state immunization registries, and will remain confidential and not released except as permitted or required by law. I agree to remain near the vaccination for approximately 15-20 minutes after administration for observation by the healthcare provider.

Signature of patient/parent or legal guardian:_____ Date:_____

For pharmacy use only

Vaccine name: _____ Manufacturer: _____ Dose: _____ Series #: _____ of _____ Vaccine Lot #: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____ Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given: ____/____/____	Vaccine name: _____ Manufacturer: _____ Dose: _____ Series #: _____ of _____ Vaccine Lot #: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____ Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given: ____/____/____	Vaccine name: _____ Manufacturer: _____ Dose: _____ Series #: _____ of _____ Vaccine Lot #: _____ Vaccine Exp. Date: _____ Diluent Lot #/Exp. Date: _____ Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given: ____/____/____
Immunizer: _____ Date Administered: _____		