Immunization Consent Form

Name (as it appears on insurance card): ____

Date of Birth: ______________ *Age:* ________________ *Gender (circle one): Male / Female*

Street Address: ____________________ *Phone Number:* ________________________

City: ______________________ *State:* _______________ *Zip Code:* ____________

Method of payment (circle one): Cash / Insurance (please provide card to pharmacy) Allergies: ______________________

Primary Care Physician (PCP): _______________________ Physicians Phone Number: ___________________

PCP address: ______________ City: _____________ State: ___________ Zip Code: _______________

Which vaccine(s) would you like to receive today? ____

Screening Questions (if you answer yes, please explain below) — Please circle

1. Are you sick today? Yes No
2. Do you have allergies to latex, medications, food or vaccines (examples: bovine protein, gelatin gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? Yes No
3. Do you have a serious allergy to eggs? Yes No
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diseases), anemia, or other blood disorder? Yes No
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis) or other nervous system problem? Yes No
6. Do you take cortisone, prednisone or other steroids? Yes No
7. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant? Yes No
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Yes No
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes No
10. Have you received any vaccinations or vaccine skin tests in the past 4 weeks? Yes No
11. Are you currently on home infusions, weekly injections such as Humira (adalimumab), Remicade (infliximan) or Enbrel (etanercept), high dose methotrexate, azathioprine or 6-mercaptopurine, antiviral, anticancer drugs or radiation treatments? Yes No
12. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? Yes No

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third-party payer as needed and request payment of authorized benefits to be made on my behalf to Health-Rite Pharmacy

- *I acknowledge that if my 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 acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting*
- *I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area, for 20 minutes, after the administration of the immunization.*
- *I acknowledge receipt of Health-Rite Pharmacy Notice of Privacy Practices for Protected Health Information*
- *I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.*
- *I have read, or have had 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 Health-Rite Pharmacy, its affiliates, officers' directors, and employees from any liability for illness, injury, loss, or damage which may result there from.*

Patient Signature or legal guardian signature: x __________________________ **Date:** ________________

PHARMACY USE ONLY

VACCINE:	VACCINE:	VACCINE:
LOT #:	LOT #:	LOT #:
EXP. DATE:	EXP. DATE:	EXP. DATE:
SITE (CIRCLE ONE) RA or LA	SITE (CIRCLE ONE) RA or LA	SITE (CIRCLE ONE) RA or LA

Signature of pharmacist who administered Vaccine(s) and provided VIS to patient: x ____________________________

Date: ____________________