Immunization Consent Form

Patient Legal Name: _____

Date of Birth: _____ Age: _____ Phone Number: _____Gender (circle one): M/F

Street Address: _____

City: _____ State: _____ Zip Code: _____

CIRCLE ALL THAT APPLY: FLU, SHINGRIX, PREVNAR13, PNEUMOVAX, MEASLES, TDAP, MENINGITIS

Screening Questions (if you answer yes, please explain below)	Please circle	
1. Are you sick today?	Yes	No
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	Yes	No
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
7. Have you had a seizure or a brain or other nervous system problem?	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 in the past 4 weeks?	Yes	No

Consent and waiver: I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the **standing order physician (Dr. Kenneth Johnston)** and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have received a copy of the pharmacy's privacy policies according to HIPPA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. I am aware that an immunization certified student pharmacist might be administering this medication. **I agree to receiving the vaccination outside of the designated vaccination area in the Pharmacy. I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Signature of patient X:_____

Date:_____Below is for pharmacy documentation

☐ Medication:_____ VIS Date: _____ Lot #:_____ Exp Date: _____ Site: ____

☐ Medication:_____ VIS Date: _____ Lot #:_____ Exp Date: _____ Site: ____

Administered by: _____ Title: _____ Date Given:_____

Pharmacist Immunization Program
Improving Arkansas wellness.