Crimson Valley Pharmacy

VACCINE ADMINISTRATION CONSENT FORM

Patient's First Name: _____Last Name: _____

Date of Birth: ____/_____/_____ Age: _____ ◯ Male ◯ Female

Address: _____City/State/Zip_____

Cell/Home phone: (_____) _____-_____ E-mail address: _____

Drug Allergies: _____

Do you have health insurance? If yes, BIN#_____PCN#_____ID#_____GRP#_____

Please answer the following questions.	Yes	No
1. Are you sick today?	◯	◯
2. Do you have any allergies to food (i.e. eggs), latex or any vaccine component (i.e.neomycin, formaldehyde, gentamicin, thimersol, bovine protein, phenol, polymyxin, gelatin, yeast)?	◯	◯
3. Have you ever had a serious reaction after receiving a vaccine?	◯	◯
4. Have you had a seizure, or other nervous system condition (Guillain-Barre Syndrome)?	◯	◯
5. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	◯	◯
6. Do you take high dose steroids such as prednisone or anticancer drugs?	◯	◯
7. Have you had x-ray therapy radiation treatments or been given immunoglobulin?	◯	◯
8. Have you received any vaccines in the past 4 weeks? If yes, vaccine? _____	◯	◯
9. **For patients over 65 <u>OR</u> if you smoke:** have you had a pneumonia or Prevnar vaccine?	◯	◯
10. **For patients aged 16-24:** Have you had a Meningitis vaccine?	◯	◯
12. **For patients aged 9-45:** Have you had an HPV vaccine?	◯	◯

I have read, the Vaccine Administration Sheet and have had a chance to ask questions, which were answered to my satisfaction, and understand the benefits and risks of the vaccination. I request that the vaccine be administered to me (or the minor for whom I represent and am authorized to sign the consent) and have been advised to wait in the vaccination area for approximately 15 minutes after vaccine administration for observation by the pharmacist. I, for myself (and the recipient of the vaccination, if the recipient is a minor), my heirs and personal representatives, hereby release any liability to Crimson Valley Pharmacy or the pharmacist from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccines administered. I authorize release of any medical information necessary to process a Medicare or other insurance claim or to health care professionals regarding patient care. I understand I am responsible for copays or if payment is denied by my insurance carrier.

X _____ Date: _____

Signature of patient or legal representative

For pharmacy use only

Crimson Valley Pharmacy

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VACCINATION RECORD

Vaccine	Lot#	Exp Date	Manufacturer	Dosage	Route of Admin	Injection Site
Afluria Quad			Sequiris	0.5ml	IM	L/R Deltoid
Fluad			Sequiris	0.5ml	IM	L/R Deltoid
Flumist			Astrazenaca	1ml	Nasal	N/A
Shingrix			Merck	0.5ml	IM	L/R Deltoid
Prevnar-20			Pfizer	0.5ml	IM	L/R Deltoid
Adacel			Sanofi	0.5ml	IM	L/R Deltoid

Signature of Administering Pharmacist/Technician: _____ Date of Administration: _____

Scanned: _____

Vaccination reported to USIIS: _____ (date