

INFORMED CONSENT FOR IMMUNIZATIONS

Race: Asian American Indian/Alaska Native Black/African American Pacific Islander White/Caucasian Other: City: State: Zip: State: Zip:	Name:	Date of Birth:	Phone N	Number:_			
Pacific Islander White/Caucasian Other:					Sex	: M	F
Weis Pharmacy will notify your physician? Y N Weis Pharmacy will notify your physician if you do not select an option above Weight (for those under 18 years old): Consent for Administration of the Following Vaccines Hepatitis A Hepatitis B Herpe Zoster Human Papillomavirus Hepatitis A Hepatitis B Herpe Zoster Human Papillomavirus Human Papillo	Asian American mulan/Alaska Native Diack				Hispanic o	r Latino	
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Does this person have fever, diarrhea, vomiting, or any other illness within the last 2 days? Do you have COVID-19 or live with someone who has COVID-19 currently? Has this person ever had a severe reaction to any vaccine, which required medical care? Is this person allergic to eggs, baker's yeast, streptomycin or neomycin? Is this person or anyone in the home being treated with biological medications, steroids, chemotherapy, radiation for cancer, have HIV/AIDS, or any immune deficiency disease? Does this person have a seizure disorder, brain disorder, history of Guillain-Barre Syndrome, or nervous system disorder? Does this person have a seizure disorder, brain disorder, history of Guillain-Barre Syndrome, or nervous system disorder? Does this person have any long-term health conditions? (ex: heard disease, diabetes, asthma, COPD, kidney disease, etc.) Has this person had immune globulin or a blood transfusion in the past year? Has this person pregnant, or planning pregnancy in the next three months? Please circle all of the following conditions that apply to the person receiving a vaccine Diabetes Asthma/COPD Smoker Heart Disease College Student Age over 50 Age over 65 have read, or have had read to me, the information regarding the vaccine/vaccines listed above. I have had the proportional to ask questions that were answered to my satisfaction. I understand the benefits and risks of the accine/vaccines and have provided an accurate vaccine history. I consent to, or give consent for, the administration of the vaccine/vaccines marked above to: Patient Name (print) Signature of Patient or Parent/Guardian if under age 18 Date By signing and giving consent, Parents/Guardian if under age 18 Date By signing and giving consent, Parents/Guardian if unders are legally allowed to do so. Immunizations given will be reported to local or state immunization registries as required unless otherwise requested As a part of our current efforts to protect you and our staff, you will be required to wear a mask		Influenza	Measles, Mumps, Rubella	Meningococca	l Mpox	Polio	-19
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