INFORMED CONSENT FOR IMMUNIZATIONS

Name:_____ **Date of Birth:**_____ **Phone Number:**_____

Food/Drug Allergies:_____ **Sex: M F**

Race: Asian American Indian/Alaska Native Black/African American Pacific Islander White/Caucasian Other: _____

Ethnicity : Hispanic or Latino Non-Hispanic or Latino Decline to State

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Primary Care Physician:_____ **Would you like us to 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 Herpes Zoster Human Papillomavirus
Influenza Measles, Mumps, Rubella Meningococcal Mpox Polio
Pneumococcal Rabies RSV DTaP TD TDaP Varicella COVID-19

Please read the questions below. Indicate Yes or No for the person receiving a vaccine today	**Yes**	**No**
1. Does this person have fever, diarrhea, vomiting, or any other illness within the last 2 days?	____	____
2. Do you have COVID-19 or live with someone who has COVID-19 currently?	____	____
3. Has this person ever had a severe reaction to any vaccine, which required medical care?	____	____
4. Is this person allergic to eggs, baker's yeast, streptomycin or neomycin?	____	____
5. 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?	____	____
6. Does this person have a seizure disorder, brain disorder, history of Guillain-Barre Syndrome, or nervous system disorder?	____	____
7. Does this person have any long-term health conditions? *(ex: heart disease, diabetes, asthma, COPD, kidney disease, etc.)*	____	____
8. Has this person had immune globulin or a blood transfusion in the past year?	____	____
9. Has this person received any vaccinations in the past 4 weeks?	____	____
10. Is 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

I have read, or have had read to me, the information regarding the vaccine/vaccines listed above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine/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/Guardians attest that they 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 during the immunization. If you do not have a mask, a disposable one will be provided to you.

This Section to be Completed by Pharmacist and/or Administrator

Date	Vaccine	Manufacturer	Lot #	Expiration	Dose	Site	VIS Date	Monitoring Completed
						□ R-Deltoid □ L-Deltoid □ R-Arm (outer aspect) □ L-Arm (outer aspect)		□ Yes □ No
						□ R-Deltoid □ L-Deltoid □ R-Arm (outer aspect) □ L-Arm (outer aspect)		□ Yes □ No

Name of administrator of vaccine:_____Signature:_____Date:_____

Supervising Pharmacist if not the Administrator: _____ Signature: _____