

Vaccine Administration Consent Form



Section A (Please print clearly.)

First name:	Last name:		
Age:	Date of birth:	Gender (check one): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary	
Race: <input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> non-Hispanic			
Home address:			
City:	State:	ZIP Code:	
Email address:		Phone number:	
Primary care physician name:		Physician phone:	Physician fax:

Please check the vaccinations you wish to receive today.

<input type="checkbox"/> Seasonal Influenza	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Meningococcal
<input type="checkbox"/> COVID-19	<input type="checkbox"/> Chickenpox (varicella)	<input type="checkbox"/> Tetanus/TDap	<input type="checkbox"/> MMR
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> HPV	<input type="checkbox"/> Shingles (zoster)	<input type="checkbox"/> Other

Section B (The following questions will help us determine your eligibility for vaccination today.)

General Vaccine Screening Questions	Yes	No
1. Do you feel sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any health conditions such as heart disease, diabetes or asthma? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a reaction (allergic or otherwise) after receiving an immunization, including fainting or feeling dizzy?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	<input type="checkbox"/>	<input type="checkbox"/>
7. For women: Are you pregnant or considering becoming pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>
Live vaccines	Yes	No
8. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list:	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you currently on home infusions, weekly injections such as Humira™ (adalimumab), Remicade™ (infliximab) or Enbrel™ (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you currently taking high-dose steroid therapy (prednisone > 20 mg/day or equivalent) for longer than two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you currently taking any antibiotics, antiviral or antimalarial medications? (Typhoid only)	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	<input type="checkbox"/>	<input type="checkbox"/>
14. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?	<input type="checkbox"/>	<input type="checkbox"/>

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Section C

COVID-19 Vaccine Screening Questions	Yes	No
16. Have you ever received a dose of COVID-19 vaccine? If yes, which product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product If yes, will this be your <input type="checkbox"/> 2nd dose or <input type="checkbox"/> 3rd dose Date of last dose:	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an allergic reaction to a component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none">• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures• Polysorbate, which is found in some vaccines, film-coated tablets and intravenous steroids<ul style="list-style-type: none">- A previous dose of COVID-19 vaccine <small>(This includes a severe allergic reaction, such as anaphylaxis, that required treatment with epinephrine or EpiPen™, or that caused you to go to the hospital. It also includes an allergic reaction that caused hives, swelling or respiratory distress, including wheezing.)</small>	<input type="checkbox"/>	<input type="checkbox"/>
18. Check all that apply to you: <input type="checkbox"/> Am a female between ages 18 and 49 years old <input type="checkbox"/> Am a male between ages 12 and 29 years old <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection <input type="checkbox"/> Have a weakened immune system (e.g., HIV, cancer) or take immunosuppressive drugs or therapies <input type="checkbox"/> Have a bleeding disorder <input type="checkbox"/> Take a blood thinner <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have received dermal fillers <input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)		

Section D (Consent and Release)

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of person to receive vaccine and VIS: _____

Date: _____

(or parent/guardian, if recipient is younger than 18 years)

Insurance information and authorization:

I hereby authorize the pharmacy to bill my insurance on my behalf for the immunizations and receive payment.

Non-medicare	Pharmacy	Medical	Medicare Card No. (Red, White and Blue Card)
Insurance plan name			
Member/recipient ID			
RX Bin		NA	
RX PCN		NA	
Group No.			

Vaccine	MFR	Date admin.	Vaccine lot No.	Exp. date	Dosage	Injection site	VIS/EUA date	Dose in series
COVID-19								
Influenza								
Other								

Immunizer name (print): _____

Immunizer signature: _____