INFORMED CONSENT TO RECEIVE VACCINES

First Name | *MI* | *Last Name*

Home Phone | *Date of Birth (mm/dd/yyyy)* | *Age* | *Gender* (M F)

Home Address | *City* | *State* | *Zip Code*

Email Address | *Medicare Part B Number (if applicable)*

Primary Care Physician/Provider Name (if known) | *Physician/Provider Phone*

Physician/Provider Address | *City* | *State* | *Zip Code*

	The following questions will help us determine your eligibility to be vaccinated today.	Yes		No		Don't Know
ALL VACCINES	1. Which vaccines are you requesting to have administered today? Please check all requested vaccines: ___Flu Shot ___Flu Nasal Spray (live–ages 2-49 only) ___Flu HD or FluAd (ages 65+) ___Pneumonia ___ Shingles ___Other_____					
	2. Do you feel sick today?	___		___		___
	3. Do you have allergies to medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal). If yes, please list the allergies:_____	___		___		___
	4. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list the vaccination.	___		___		___
	5. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?	___		___		___
	6. 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?	___		___		___
	7. Are you 65 years of age or older?	___		___		___
	8. Do you smoke?	___		___		___
	9. Do you have a chronic condition or long-term health problem**? If yes, please check all that apply.** ___Anemia ___Asthma ___Diabetes ___Heart disease ___Kidney disease ___Liver disease ___Lung disease ___Other	___		___		___
	10. If you answered YES to question #7, 8 or 9, have you ever had a pneumonia vaccination?	___		___		___
	11. Have you ever had a shingles vaccination (for patients 50 years of age and older only)?	___		___		___
	12. Are you a healthcare worker?	___		___		___
	13. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)					
	14. **For women: Are you pregnant or considering becoming pregnant in the next month?**	___		___		___
LIVE VACCINES	15. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatments?	___		___		___
	16. 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?	___		___		___
	17. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	___		___		___
	18. If the patient receiving vaccine is under 5 years old, is there a history of asthma or wheezing? (for FluMist® only)	___		___		___
	19. Does the patient have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for FluMist® only)	___		___		___

I have read, or have had read to me, the Vaccine Information Statement (VIS) referred to above. I have had the opportunity to ask questions about the vaccine(s), and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to the administration of the vaccine(s) requested. I authorize the information to be forwarded to my primary care physician, the authorizing physician, Utah State Immunization Information System (USIIS), or the local Dept. of Health, if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Patient Signature: _____ Date: _____
(Parent or Guardian, if minor)

Please initial that you have received our Notice of Privacy Practice for HIPAA

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Vaccine Information (Office use only)

Vaccine	Lot #	Exp. Date	Manufacturer	Dose (ml)

Route	*Right or Left Arm* Admin. Site	Admin. Date	VIS Date (on form)

Administrator*	Store # (where pt receives vaccine)

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By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine.

ADHERE LABELS HERE