Consent for Vaccination

Section A Please print clearly

LAST NAME | FIRST NAME | MI | GENDER (M/F)

ADDRESS | CITY | STATE | ZIP

( ) | / / | |

PHONE NUMBER | MEDICARE B # (IF APPLICABLE) | DATE OF BIRTH | AGE

( )

PRIMARY CARE PHYSICIAN/PROVIDER NAME | PHYSICIAN/PROVIDER ADDRESS | PHYSICIAN/PROVIDER PHONE

Section B Please answer the following question to determine if you are eligible to receive a vaccination today

	Yes	No	Don't Know
1. Which vaccine are you requesting to have administered today? Please check all requested vaccine(s). ☐ Inactivated Influenza(flu) ☐ Intranasal Influenza ☐Pneumonia ☐ Shingles ☐Tdap (Whooping Cough) ☐Other: _____			
2. Do you feel sick today?	☐	☐	☐
3. Do you have allergies to medications, food, or vaccines? (Example: eggs, gelatin, gentamicin, polymyxin, neomycin, phenol, thimerosal or latex) 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/skin test:_____	☐	☐	☐
5. Have you ever had a serious reaction to any 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, or other nervous system problems?	☐	☐	☐
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 ☐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. For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐	☐
13. Are you currently on a blood thinning medication such as warfarin or aspirin therapy?	☐	☐	☐
For Live Vaccine (Shingles, Chicken Pox, Nasal flu, etc):			
14. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, or radiation treatment?	☐	☐	☐
15. 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?	☐	☐	☐
16. Have you received a transfusion of blood or blood products or have you been given a medicine called immune (gamma) globulin in the past year?	☐	☐	☐
17. Do you have a nasal condition serious enough to make breathing difficult, such as a very stuffy nose? (for nasal vaccines only)	☐	☐	☐

Section C

I certify that I am: (i) the patient and at least 18 years of age; (ii) the parent or legal guardian of the minor patient; or (iii) the legal guardian of the patient. Further, I hereby give my consent to the Hartig Drug immunization certified pharmacist, or intern (under the direct supervision of a pharmacist), to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering provider. On behalf of myself, my heirs and personal representative, I hereby release and hold harmless Hartig Drug, its staff, and employees 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 vaccine(s) listed above. I understand that my state may offer participation in a state immunization registry, in which case my immunization information may be supplied to the state unless I complete a state-approved opt-out process. Hartig Drug, will, if my state permits, provide me with an opt-out form. Unless I provide Hartig Drug with a signed opt-out form, I elect to participate fully in, and consent to Hartig Drug reporting my immunization information to the state's immunization registry. I authorize Hartig Drug to (1) release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payers as necessary to facilitate care or payment, (2) submit a claim to my insurer for the above requested items and services, and (3) request payment of authorized benefits be made on my behalf to Hartig Drug with respect to the above requested items and services. I further agree to be fully financially responsible for any due amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of services or if Hartig Drug invoices me after the time of service, upon receipt of such invoice.

Patient/Legal Representative Signature:_____ **Date:**_____

FOR PHARMACY USE ONLY

Vaccine	Lot#	Exp Date	Manufacturer	Dosage	Site	VIS Date

Immunizer Name (print):_____ Immunizer Signature:_____ Date:_____