**Vaccine Consent & Assessment**

**Last Name**: (write below) **First Name**: **M**I: **Date of Birth**: **Age**:

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**Home Address: City**: **State**: **Zip Code**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Phone Number: Primary Care Provider Name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Arm for Injection:** (circle one) **LEFT** / **RIGHT**

**I WOULD LIKE THE FOLLOWING VACCINES TODAY (** PLEASE CIRCLE ALL THAT APPLY**)**

**Flu** - ( High Dose 65+ / Quadrivalent ) **Pneumonia** - ( PREVNAR-13™ / PNEUMOVAX-23™ )

**Tetanus, Diphtheria, Pertusis** (Tdap)  **Shingles** (Shingrix™)

**PLEASE ANSWER THE FOLLOWING QUESTIONS SO WE CAN ASSESS THE SAFETY AND APPROPRIATENESS OF VACCINATION:**

1. Do you have a fever or illness today? **YES / NO**
2. Do you have any allergies to medications, foods (e.g. eggs), latex or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? **YES / NO** If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you have a long-term health problem with heart/lung/kidney/metabolic disease (e.g. diabetes), asthma, anemia, or other blood disorder? **YES / NO** if yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. In the past 3 months, have you taken medication that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn’s disease, or psoriasis; or have had radiation treatments? **YES / NO** if yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. During the past year, have you received any blood transfusion, or blood products, or been given immune (gamma) globulin or an antiviral drug? **YES / NO** if yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? **YES / NO**
7. Have you ever had a serious reaction after receiving a vaccine?

(swelling, trouble breathing, seizure, etc.) **YES / NO**

1. Have you ever experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder? **YES / NO**
2. Have you previously received any of the vaccine(s) you are requesting today? **YES / NO**
3. Have you received any vaccines in the past 28 days? **YES / NO** if yes, list vaccine / date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **FOR WOMEN**: Are you currently pregnant, breastfeeding, or are you planning to become

pregnant in the next month? **YES / NO**

**»TURN PAGE OVER«**

**PLEASE READ AND SIGN BELOW:**

I hereby give my consent to the healthcare provider of Legacy Good Samaritan Apothecary to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccines(s) being administered and have received, read and/or had explained to me the CDC’s Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I fully release and hold harmless Legacy Good Samaritan Apothecary and its subsidiaries, affiliates, divisions, officers, directors, contractors and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries, and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Legacy to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. **Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering healthcare provider.**

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

(SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT IS UNDER 18) (\*FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP ABOVE) **DATE**

**FOR PHARMACY USE ONLY –** The following section is to be completed by the pharmacy: Legacy Good Samaritan Apothecary

|  |  |  |
| --- | --- | --- |
| **Vaccine name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Manufacturer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Dose**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Vaccine lot**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Vaccine Exp. Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Diluent Lot #/Exp. Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Vaccine name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Manufacturer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Dose**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Vaccine lot**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Vaccine Exp. Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Diluent Lot #/Exp. Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Vaccine name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Manufacturer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Dose**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Vaccine lot**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Vaccine Exp. Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Diluent Lot #/Exp. Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Injection Site: LEFT ARM RIGHT ARM**  **Route: IM SUBQ**  Date and Time Administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date VIS Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  VIS Version Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Injection Site: LEFT ARM RIGHT ARM**  **Route: IM SUBQ**  Date and Time Administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date VIS Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  VIS Version Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Injection Site: LEFT ARM RIGHT ARM**  **Route: IM SUBQ**  Date and Time Administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date VIS Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  VIS Version Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Immunizer Signature / Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Information contained on this form derived from the CDC [www.immunize.org/catg.d/p4065.pdf](http://www.immunize.org/catg.d/p4065.pdf), item #p4065 (8/17)

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