Informed Consent to Receive Vaccines

Patient Info

Name:_____ **Date of Birth:**_____ **Male/Female**

Address/Facility:_____

City:_____ **State:**_____ **Zip:**_____

Phone: ( )_____ **Insurance: Yes/No (If yes-please present card)**

By signing this form I am acknowledging that I have read and understand the Vaccine Information Statement (VIS Form) and the Notice of Privacy Practice for HIPAA provided to me. I have answered all of the question found on page 2 and any questions I may have regarding vaccines have been addressed to my satisfaction. I am giving my consent for the vaccine that is to be administered. I authorize this information to be forwarded to my primary care physician, insurance plan, or other health care official if applicable. I agree to stay in the general area for 15 minutes after receiving the vaccine 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 herby release the pharmacy that is administering the vaccine, the pharmacist administering the vaccine, Family Pharmacy Inc. and all of it's directors, officers, employees, agents; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any liability that might arise from this vaccination.

_____ _____

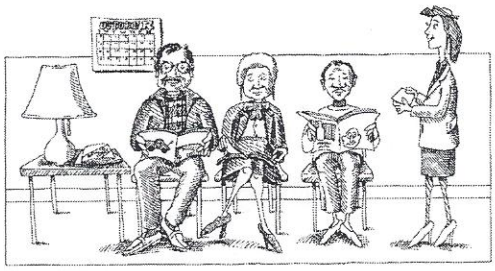
Patient/Caregiver Signature **Date**

_____ _____ _____ _____

Vaccine **Lot#** **Exp. Date** **Adm Site (R or L Arm)**

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Item #IF4065 (4/09)

Printed by Immunization Action Coalition • Saint Paul, MN • (651) 647-9009 • www.immunize.org/shop