Vaccine Consent and Administration Form

Name:_____ Age:_____ Date of Birth:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Primary Care Provider:_____ Physician's Phone number:_____

PLEASE INDICATE ALL OF THE VACCINES YOU WANT TO RECEIVE TODAY:

□ Flu	□ Prevnar	□ Shingles	□ Tetanus, Diptheria, Pertussis (Tdap)
□ FluMist	□ Pneumovax	□ Hepatitis A	□ Other:_____
□ Flu- High Dose (≥ 65 years old)	□ HPV	□ Hepatitis B	

PLEASE ANSWER THE FOLLOWING QUESTION FOR *ALL* VACCINES:	YES	NO
1. Do you have a fever or illness today?		
2. Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?		
3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?		
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.?) If yes, please indicate what you are allergic to:_____		
3. Have you ever had a serious reaction after receiving a vaccine? (Lip swelling, arm swelling, trouble breathing, seizures, etc.)		
4. Have you ever received the same vaccine that you are requesting today? If so, when?		
5. Have you ever experienced seizures, Guillain-Barre syndrome, or any other neurological/brain disorder?		
6. Have you received any vaccines in the past 28 days? If so, please list vaccine and date:_____		
7. Do you have heart disease, COPD, asthma, kidney disease, liver disease, diabetes, or any other immunocompromising condition?		
8. Have you had a mastectomy? If yes, please circle: Left Right Both		
9. For women: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
10. Have you received a Shingrix (shingles) vaccine (for patients 50 years of age and older)?		
11. Have you previously received a pneumonia vaccine?		
FOR *LIVE* VACCINES ONLY, PLEASE ANSWER THE FOLLOWING:		
10. Do you have cancer, leukemia, lymphoma, HIV/Aids, organ transplantation, or any other immune system problem?		
11. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, antiviral medications such as acyclovir or famciclovir, Chron's Disease or psoriasis, or had radiation treatments? If so, please list medication, dose, and date last taken:_____		
12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
13. Are you currently living with or expected to be in close contact with someone with a severely weakened immune system who must be in protective isolation (e.g. a bone marrow transplant recipient)?		
14. Have you experienced wheezing in the last 12 months?		

I have read, or have had read to me, the Vaccine Information Statement. I have had the opportunity to ask questions about the vaccine, and all of my questions were answered to my satisfaction. I understand the benefits and risks, and I consent to the administration of the vaccine requested. I authorize the information to be forwarded to my primary care physician, the authorizing physician, and the local Department of Health, if applicable. I agree to say 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 Pharmacist that is administering the vaccine, Clark's Market, subsidiaries and affiliates of Clark's Market, and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any liability that might arise from the vaccination.

Patient Signature*:_____ Date:_____

*or signature of legal guardian if patient is under 18

Dear _____, Physician Fax:_____ Date:_____

Patient Name:_____ Patient DOB:_____

We administered the below vaccines to our mutual patient pursuant to CDC guidelines. The patient was counseled on minor side effects and major adverse reactions.

Clark's Pharmacy Aspen Pharmacist:_____

Notes:_____
_____

Fluarix/Flulaval Quad PFS Vaccine lot: Expiration date: 6/30/21 Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: GSK Route: IM VIS Date: 8/15/19	FluBLOK Quadrivalent PFS Vaccine lot: Expiration date: 06/30/21 Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: Seqirus Route: IM VIS Date: 8/15/19	Fluzone HD Quadrivalent PFS Vaccine lot: Expiration date: Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: Sanofi Route: IM VIS Date: 8/15/19
FluMist Vaccine lot: Expiration date: Intranasally Pharmacist Initials: Date Administered: Dose: 0.2ml Manufacturer: Med Immnune Route: Both nostrils VIS Date: 8/15/19	Prevnar 13 Vaccine lot: Expiration date: Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: Wyeth Route: IM VIS Date: 11/5/15	Pneumovax 23 Vaccine lot: Expiration date: Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: Merck Route: IM VIS Date: 4/24/15
Shingrix Vaccine lot: Expiration date: Diluent lot: Diluent exp: Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: GSK Route: IM VIS Date: 2/12/18	Tdap: Boostrix Vaccine lot: Expiration date: Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: GSK Route: IM VIS Date: 4/1/20	MMR Vaccine lot: Expiration date: Diluent lot: Diluent exp: Injection Site: L arm R arm Pharmacist Initials: Date Administered: Dose: 0.5mL Manufacturer: Merck Route: SQ VIS Date: 8/15/2019

Off Site Clinic Address: Backtag