Immunization Consent Form

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

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

Phone: _____ **Medicare Part B ID Number:** _____

Primary Care Physician Name & Address: _____

Medical Conditions: _____ **Vaccine you would like to receive:** Influenza

	YES	NO
1. Do you feel sick today?	☐	☐
2. Have you ever had a reaction after receiving a vaccine? If yes, please describe: _____	☐	☐
3. Do you have any allergies to medications, foods (e.g. Eggs), latex or any vaccines and their components (e.g. neomycin)? _____	☐	☐
4. Do you have cancer, leukemia, HIV/AIDS or any other immune system problems?	☐	☐
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray/radiation treatments?	☐	☐
6. During the past year, have you received a transfusion of blood or blood products, including antibodies?	☐	☐
7. Have you received any vaccinations in the past 4 weeks?	☐	☐
8. Do you have a neurological disorder (e.g. seizures), other disorders that affect the brain or have neurological disorder that resulted from a vaccine?	☐	☐
9. For women: Are you pregnant or is there a chance that you could become pregnant in the next three months?	☐	☐

Please select one of the following options. Failure to select one of the following options will result in release of your vaccination information to your primary care physician (if identified).

☐ I authorize release of my vaccination information to my primary care physician (if identified).

☐ I do NOT authorize release of my vaccination information to my primary care physician (if identified).

I have read the adverse reactions associated with the requested vaccine. A copy of the vaccine information sheet was provided. Furthermore, I have also had the opportunity to ask questions about these immunizations. I agree to stay in the vaccination general area for 20 minutes after receiving my vaccination in case any immediate reactions occur. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reaction that may result. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release RxOutlet, Inc. any retail site, pharmacy, corporation, physician, and/or medical director and their respective affiliates, subsidiaries, divisions, directors, contractors, agents and employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). RxOutlet, Inc. and the other aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damaged suffered or sustained by any person at any time in connections with or as a result of this vaccine program or the administration of the vaccines described above. RxOutlet, Inc. will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Notice of Privacy and Confidentiality Practices to help you better understand our policies in regards to your personal health information. I acknowledge that I have received or been offered a copy of the Notice of Privacy and Confidentiality Practices.

DocQ _____ _____

Patient Signature Date

Pharmacy Use Only

Vaccine	Lot #	Exp Date	Manufacturer	VIS Version Date	VIS Recipient / Date Given

Dose	Route	Arm	Authorizing Physician (full name)

Informed patient to remain in pharmacy area for 20 minutes after vaccination, for observation _____ (initials)

Printed Name of Pharmacist Administering Vaccination/Title	Signature of Pharmacist Administering Vaccination	Date of Administration
Piyush Patel	DocQ _____	

Address/Location of Administration: _____

Please place label and back tag on the other side of page, for filing purposes

Rev 08/14/12