MERCER ISLAND PHARMACY

Vaccine Consent and Administration Record

***Patient Name**: _____ ***Date of Birth**: _____ ***Phone:** _____

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

***Gender**: _____ ***Primary Doctor**: _____ ***Dr. Phone:** _____

***Which vaccine(s) would you like to receive today?** ☐ **Covid** ☐ **Flu** ☐ **Other:** _____

Insurance Information: Medicare ID (MBI): _____ **SSN:** _____

RxBin: _____ **RxPCN:** _____ **RxGroup:** _____ **ID:** _____

Immunization Screening Questions:	**YES**	**NO**	**Don't Know**
1. Are you sick today? (For example: a cold, fever or acute illness)			
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.)			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Have you had a seizure or other nervous system problem or Guillain Barre that resulted from a vaccine?			
5. Do you take anticoagulation medication? For example: warfarin, Coumadin or other blood thinner.			
6. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?			
7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?			
8. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?			
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
10. For women, are you pregnant or is there a chance you could become pregnant during the next month?			

Medicare Part B patients authorize the release of any medical or other information to process this claim and request payment of government benefits to either themselves or the party who accepts assignment below. If the patient's insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
I have read or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Eastern's Pharmacy, its affiliates, their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

X _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian) **Date**

Vaccine Administration Information for immunizer/Pharmacist use only

Immunizer: _____ Immunizer Signature: _____ RPh/PharmD

Administration Date: _____ Date VIS given to Patient: _____

Vaccine	**Lot#**	**Exp Date**	**Site of Injection**

Mercer Island Pharmacy

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