VASSAR PHARMACY

VACCINE CONSENT FORM

☐ RPh/Tech Name:	(Internal/Off Site Clinic Information)
☐ Phone/Fax Date: ____/____/____	
☐ Phone/Fax Time: ____:____ AM/PM	
☐ Registry Date: ____/____/____	

First Name:	MI:	Last Name:			
Home Phone: ( ) -	Date of Birth: / /	Age:	Weight:	Gender:	Ethnicity:
Home Address:	City:			State:	Zip Code:
Primary Healthcare Provider:	Provider Address:			Provider Phone/Fax: ( ) -	
Insurance Carrier:	Cardholder ID:			Group Number:	

I WANT TO BE PROTECTED FROM THE FOLLOWING (*PLEASE CHECK ALL THAT APPLY*): ☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HPV ☐ *MEASLES/MUMPS/RUBELLA (MMR)** ☐ MENINGITIS ☐ PNEUMONIA ☐ SHINGLES ☐ TDAP ☐ *VARICELLA** ☐ OTHER (PLEASE SPECIFY):_____

	Please answer the following questions so we can assess the safety and the appropriateness of vaccination:	Yes	No
ALL VACCINES	1. Do you have any of the following symptoms today? Fever, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea		
	2. In the past 14 days, have you had a fever, been exposed to or confirmed to have COVID-19, regardless of symptoms?		
	3. Have you had a physical examination by a healthcare provider in the last year?		
	4. 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 list what you are allergic to:_____		
	5. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	6. Have you had the vaccine (s) you are receiving today before?		
	7. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	8. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:_____		
	9. For **women**: Are you currently pregnant, breastfeeding, or planning to become pregnant in the next month?		
*LIVE VACCINES	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, Crohn's disease or psoriasis (e.g. Humira, Enbrel) or had radiation treatments? If yes, 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? If yes, list medication, dose, and date last taken:_____		

I hereby give my consent to the health care provider of Vassar Pharmacy, LLC, its affiliates and subsidiaries, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(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 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 Vassar Pharmacy, LLC 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. I acknowledge that I have received a copy of the Notice of Privacy Practices. **Furthermore, I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering Healthcare Provider.**

✘_____ **Date:** _____

(SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

*** FOR INTERNAL USE ONLY *** □ **REQUIRED**: obtained verbal consent to treat prior to administration □ If <18, recommend Well-Child Visit

Vaccine Name:_____	Vaccine Name:_____	Vaccine Name:_____
Manufacturer:_____	Manufacturer:_____	Manufacturer:_____
Dose:_____ Series #: _____ of _____	Dose:_____ Series #: _____ of _____	Dose:_____ Series #:_____ of _____
Vaccine Lot #:_____	Vaccine Lot #:_____	Vaccine Lot #:_____
Vaccine Exp. Date:_____	Vaccine Exp. Date:_____	Vaccine Exp. Date:_____
Diluent Lot #/Exp. Date:_____	Diluent Lot #/Exp. Date:_____	Diluent Lot #/Exp. Date:_____
Injection Site: **LEFT/RIGHT; ARM/THIGH**	Injection Site: **LEFT/RIGHT; ARM/THIGH**	Injection Site: **LEFT/RIGHT; ARM/THIGH**
Route: **IM** or **SubQ**	Route: **IM** or **SubQ**	Route: **IM** or **SubQ**
VIS Given: ____/____/____	VIS Given: ____/____/____	VIS Given: ____/____/____
Version Date: ____/____/____	Version Date: ____/____/____	Version Date: ____/____/____

☐ **REQUIRED**: counseled patient to remain near location for 15 to 20 mins Supervising RPh/Lic#:_____ *(if required)*

Immunizer:_____ Date Administered:___/___/___Time: _____AM/PM