



INFORMED CONSENT FOR IMMUNIZATIONS

Name: _____ Date of Birth: _____ Phone Number: _____

Food/Drug Allergies: _____ Sex: M F

Race: Asian American Indian/Alaska Native Black/African American Pacific Islander White/Caucasian Other: _____ Ethnicity: Hispanic or Latino Non-Hispanic or Latino Decline to State

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Would you like us to notify your physician? Y N
Weis Pharmacy will notify your physician if you do not select an option above

Weight (for those under 18 years old): _____ Consent for Administration of the Following Vaccines:

Hepatitis A	Hepatitis B	Herpes Zoster	Human Papillomavirus
Influenza	Measles, Mumps, Rubella	Meningococcal	Polio
Pneumococcal	Rabies	DTaP	TD
		TDaP	Varicella
			COVID-19

Please read the questions below. Indicate Yes or No for the person receiving a vaccine today

- | | Yes | No |
|---|-------|-------|
| 1. Has this person ever had a severe reaction to any vaccine, which required medical care? | _____ | _____ |
| 2. Is this person allergic to eggs, baker's yeast, streptomycin or neomycin? | _____ | _____ |
| 3. Does this person have fever, diarrhea or vomiting today? | _____ | _____ |
| 4. Is this person or anyone in the home being treated with biological medications, steroids, chemotherapy, radiation for cancer, have HIV/AIDS, or any immune deficiency disease? | _____ | _____ |
| 5. Does this person have a seizure disorder, brain disorder, history of Guillain-Barre Syndrome, or nervous system disorder? | _____ | _____ |
| 6. Does this person have any long-term health conditions?
(ex: heart disease, diabetes, asthma, COPD, kidney disease, etc.) | _____ | _____ |
| 8. Has this person had immune globulin or a blood transfusion in the past year? | _____ | _____ |
| 9. Has this person received any vaccinations in the past 4 weeks? | _____ | _____ |
| 10. Is this person pregnant, or planning pregnancy in the next three months? | _____ | _____ |

Please circle all of the following conditions that apply to the person receiving a vaccine

Diabetes Asthma/COPD Smoker Heart Disease College Student Age over 50 Age over 65

I have read, or have had read to me, the information regarding the vaccine/vaccines listed above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine/vaccines. I consent to, or give consent for, the administration of the vaccine/vaccines marked above to:

Patient Name (print) Signature of Patient or Parent/Guardian if under age 18 Date

Immunizations given will be reported to local or state immunization registries as required unless otherwise requested

This Section to be Completed by Pharmacist and/or Administrator

Date	Vaccine	Manufacturer	Lot #	Expiration	Dose	Site	VIS Date
						<input type="checkbox"/> R-Deltoid <input type="checkbox"/> L-Deltoid <input type="checkbox"/> R-Arm (outer aspect) <input type="checkbox"/> L-Arm (outer aspect)	
						<input type="checkbox"/> R-Deltoid <input type="checkbox"/> L-Deltoid <input type="checkbox"/> R-Arm (outer aspect) <input type="checkbox"/> L-Arm (outer aspect)	

Name of administrator of vaccine: _____ Signature: _____ Date: _____

Address of administrator: _____ City: _____ State: _____ Zip: _____

Supervising Pharmacist if not the Administrator: _____ Signature: _____