# 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 |
|---|---|---|---|---|---|---|---|
| | | | | | | □ R-Deltoid □ L-Deltoid □ R-Arm (outer aspect) □ L-Arm (outer aspect) | |
| | | | | | | □ R-Deltoid □ L-Deltoid □ R-Arm (outer aspect) □ L-Arm (outer aspect) | |

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

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

Supervising Pharmacist if not the Administrator: _____ Signature: _____