**Pharm A Save Monroe**
**17788 147th ST SE**
**Monroe, WA 98272**

# Vaccine Consent Form

Information about the person to receive the vaccine(s) (PLEASE PRINT):

Name: _______________________________________________Birthdate:____________________

Address_________________________________________________Phone_____________________

City:____________________________________ State:_________________ Zip:_________________

Allergies___________________________________________________________________________

Chronic Conditions _________________________________________________________________

Primary Care Physician________________________ Billing insurance? Yes or No – (attach copy of card)

**Requested Vaccines** (please check)
**__ Influenza __ Prevnar 13 __ Pneuovax 23 __ Zostavax (additional form needed)**
**__ Tdap __ MMR __Oral Typhoid**

**__ Engerix (Hep B) __ Twinrix (Hep A&B) Other _____________________________________________**

**"I have read or have had explained to me the information in the CDC Vaccine Information Statement(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of this/these vaccine(s) and ask that the vaccine(s) be given to me"**

___________________________________________________ _____________________
Signature Date

☐ Check here if you do not wish to have your primary physician notified of this vaccination.

****For Pharmacy Use****

| | Vaccine #1 | Vaccine #2 | Vaccine #3 |
|---|---|---|---|
| Date Administered | | | |
| Vaccine | | | |
| Manufacturer | | | |
| Lot Number | | | |
| Expiration Date | | | |
| Site & Route of Inj | L or R Deltoid | L or R Deltoid | L or R Deltoid |
| Date of VIS | | | |

_____________________________________ _____________________________________
**Generic Substitution Permitted** **Dispense As Written**

# Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ____________________

DATE OF BIRTH ____ / ____ / ____ (month / day / year)

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | yes | no | don't know |
|---|---|---|---|
| **1.** Are you sick today? | ☐ | ☐ | ☐ |
| **2.** Do you have allergies to medications, food, a vaccine component, or latex? | ☐ | ☐ | ☐ |
| **3.** Have you ever had a serious reaction after receiving a vaccination? | ☐ | ☐ | ☐ |
| **4.** Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | ☐ | ☐ | ☐ |
| **5.** Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? | ☐ | ☐ | ☐ |
| **6.** In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? | ☐ | ☐ | ☐ |
| **7.** Have you had a seizure or a brain or other nervous system problem? | ☐ | ☐ | ☐ |
| **8.** During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | ☐ | ☐ | ☐ |
| **9.** For women: Are you pregnant or is there a chance you could become pregnant during the next month? | ☐ | ☐ | ☐ |
| **10.** Have you received any vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |

FORM COMPLETED BY ____________________ DATE ________

FORM REVIEWED BY ____________________ DATE ________

**Did you bring your immunization record card with you?** yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it.