



Vaccination Permission, Release, & Screening Consent Form for Adults

Appointment Information					
Appointment Date:	Location:	Insurance Name:			
Clinical Service(s) Requested:		Member ID/Policy #:			
		Group #:	BIN: PCN:		
Patient Information					
Name:	Gender:	Date of Birth:	Phone:		
Street Address:		City:	State: Zip code:		
IF LESS than 66 lbs., list weight: _____ lbs.	PCP Name:	PCP Phone #:	PCP Fax #:		
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Other: _____					
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Decline to state/ Unknown					
Screening Questions			Yes	No	Don't Know
1. Are you sick today?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccine?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood clotting disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a parent, brother, or sister with an immune system problem?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 3 months, have you taken medicines 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?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had a seizure or a brain or other nervous system problem?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you pregnant or is there a chance you could become pregnant during the next month?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you received any vaccinations (e.g., flu, shingles, COVID-19) in the past 4 weeks?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- I authorize the Pharmacy to submit a claim to my insurer for the above requested service(s) and request payment of authorized benefits be made on my behalf to the Pharmacy.
- I fully understand that I will ultimately be responsible for any charges if I am not a covered person under the insurance plan I provided, the services are not covered services, or for any co-pays, deductibles or coinsurance obligations that apply.
- I certify that I am the patient and at least 18 years of age; the legal guardian of the patient; or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves.
- I have been provided the Vaccine Information Statement or Emergency Use Authorization Fact Sheet for Recipients & Caregivers for the vaccine(s) to be administered and understand the risks and benefits.
- **I GIVE CONSENT** to the pharmacy and its staff for myself, or the person listed above to be vaccinated with the vaccine(s) requested above.

I hereby certify that the above information is true and correct to the best of my knowledge and I agree to the terms and conditions stated above.

PATIENT NAME: _____
(Please print clearly)

PATIENT SIGNATURE: _____ DATE: _____
(Parent or guardian, if minor)

PHARMACY USE ONLY

VACCINE(S) GIVEN

Vaccine	NDC	Manufacturer	Dose	VIS	Lot #	Exp. Date	Site of Admin	Route of Admin
<input type="checkbox"/> Influenza (Injectable)							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Shingles							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Pneumococcal							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> RSV							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Tdap							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> COVID-19							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Hep. A							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Hep. B							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Hep. A & B							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Meningococcal							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM <input type="checkbox"/> SQ
<input type="checkbox"/> MMR							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> SQ
<input type="checkbox"/> Varicella							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> SQ
<input type="checkbox"/> IPV							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM <input type="checkbox"/> SQ
<input type="checkbox"/> Hib							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> HPV							<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
<input type="checkbox"/> Other:							<input type="checkbox"/> LA <input type="checkbox"/> RA <input type="checkbox"/> LN <input type="checkbox"/> RN	<input type="checkbox"/> IM <input type="checkbox"/> SQ <input type="checkbox"/> NASAL

PHARMACIST/INTERN SIGNATURE: _____

ADMINISTRATION DATE: _____

DATE VIS GIVEN TO PATIENT: _____