



Vaccination Permission, Release, & Screening Consent Form for Adults

Patient Information					
Name:	Gender: M / F	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: ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Black or African American ☐ Caucasian ☐ Other: _____					
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to state/ Unknown					
Screening Questions			Yes	No	Don't Know
1. Are you sick today?			☐	☐	☐
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?			☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?			☐	☐	☐
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?			☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?			☐	☐	☐
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?			☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?			☐	☐	☐
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?			☐	☐	☐
10. Are you pregnant or is there a chance you could become pregnant during the next month?			☐	☐	☐
11. Have you received any vaccinations (e.g., flu, shingles, COVID-19) in the past 4 weeks?			☐	☐	☐

- 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
☐ Influenza (Injectable)							☐ LA ☐ RA	☐ IM
☐ Shingles							☐ LA ☐ RA	☐ IM
☐ Pneumococcal							☐ LA ☐ RA	☐ IM
☐ RSV							☐ LA ☐ RA	☐ IM
☐ Tdap							☐ LA ☐ RA	☐ IM
☐ COVID-19							☐ LA ☐ RA	☐ IM
☐ Hep. A							☐ LA ☐ RA	☐ IM
☐ Hep. B							☐ LA ☐ RA	☐ IM
☐ Hep. A & B							☐ LA ☐ RA	☐ IM
☐ Meningococcal							☐ LA ☐ RA	☐ IM ☐ SQ
☐ MMR							☐ LA ☐ RA	☐ SQ
☐ Varicella							☐ LA ☐ RA	☐ SQ
☐ IPV							☐ LA ☐ RA	☐ IM ☐ SQ
☐ Hib							☐ LA ☐ RA	☐ IM
☐ HPV							☐ LA ☐ RA	☐ IM
☐ Other:							☐ LA ☐ RA ☐ LN ☐ RN	☐ IM ☐ SQ ☐ NASAL

PHARMACIST/INTERN SIGNATURE: _____

ADMINISTRATION DATE: _____

DATE VIS GIVEN TO PATIENT: _____