Medicine Tree Pharmacy

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Immunization Consent Form

I have been given a copy and have read, or have had explained to me, the information in the "Vaccine Information Sheet" for each vaccine checked below. I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of each vaccine requested and ask that the vaccine(s) checked below be given to me or to the patient for whom I am authorized to make this request.

- ☐ Tdap (Tetanus/Diptheria/Acellular Pertussis)
- ☐ Hep A (Hepatitis A)
- ☐ Hep B (Hepatitis B)
- ☐ HPV (Human Papillomavirus)
- ☐ Meningococcal
- ☐ Pneumococcal (PPV23)
- ☐ Rabies
- ☐ Typhoid (IM)
- ☐ Zoster (Shingles)
- ☐ MMR (Measles/Mumps/Rubella)
- ☐ Yellow Fever
- ☐ Other:_____

You should not receive a vaccine if:
You have ever had a serious allergic reaction to eggs, thimerosal preservative or to a previous dose of this vaccine.
You have a history of Guillain-Barre' Syndrome (GBS)
You are ill.

Speak to your doctor if you are pregnant.

Name: (Last)_____ (First)_____ (Middle Initial)_____

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

Date of Birth:_____

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing high fever? ___Yes ___No
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past? ___Yes ___No
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction? ___Yes ___No
4. Has the person to be vaccinated had a seizure or other neurological problem? ___Yes ___No
5. Is the person taking cortisone, prednisone, other steroids or anti-cancer drugs? ___Yes ___No
6. Has the person received blood plasma or immune globulin in the past 12 months? ___Yes ___No
7. Has the person to be vaccinated had Guillain-Barre' Syndrome? ___Yes ___No

Possible Reaction(s):
Mild: soreness or redness at the site of the shot, fever, body aches
Severe: Acute Allergic Reaction - high fever, confusion, difficulty breathing, hives, rapid heartbeat (would occur within a few minutes of the shot) Guillain-Barre' Syndrome - progressive muscle weakness and paralysis (may occur a week after the vaccine - occurs in 1-2 cases per million persons vaccinated)

Signature of Patient/Parent/Legal Guardian:

X_____Date:_____

For Staff Use Only

Date Vaccine Given:	***Site:***	***Lot#***	***Mfr:***	***Dose:***
Date on VIS:	***Date VIS Given:***		***Initials of Vaccinator:***	