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:____________________
- ☐ Influenza (IM)
- ☐ Influenza (Intranasal)

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: ____________________ **Phone:** ____________________

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
8. Has the person received Nasal Flu, MMR, Varicella or Zoster vaccine in the last 4 weeks? ___Yes ___No
9. Has the person taken antiviral medication in the last week? (Relenza or Tamiflu) ___Yes ___No
10. Does the person have chronic health problems: Asthma, Diabetes, sickle cell, heart, lung, or Kidney disease? ___Yes ___No
11. Does the person have a weakened immune system? (Cancer, leukemia, AIDS or HIV) ___Yes ___No

Signature of Patient/Parent/Legal Guardian:

X____ **Date:**____________________

For Staff Use Only

Date Vaccine Given:	*Vac Initials:*	*Site:*	*Mfr:*	*Dose:*
Date on VIS:	*Date VIS Given:*	*Lot#:*		*Exp Date:*