Richard's PHARMACY

8/18/2020

VACCINE ADMINISTRATION CONSENT FORM

I agree that the person named below will receive the vaccine indicated and that this person will have a vaccine administered by injection to prevent infectious disease. I acknowledge that I received a current copy of the Vaccine Information Statement for this vaccine and have had the opportunity to ask questions concerning the benefits and risks of the vaccine and the diseases it prevents. I understand that I may be asked to stay near the pharmacy at least 15 minutes after the vaccine has been administered to ensure that no adverse reactions will occur. I freely and voluntarily authorize the administration of these vaccines to me or the person named below for whom I am authorized to make this decision.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

__Yes __No Are you sick today? Do you have any of these symptoms: fever, chills, shortness of breath, body aches, loss of taste/smell

__Yes __No In the last 10 days, have you or someone with whom you've been in close contact been diagnosed with Covid-19?

__Yes __No Do you have any allergies to eggs, gelatin, food, neomycin, other medications, or vaccines?

__Yes __No Have you ever had a serious reaction to a vaccine?

__Yes __No Are you taking biological injectables, steroids, anticancer drugs, antivirals, or have you had recent radiation treatments?

__Yes __No Do you have a problem with your immune system, history of AIDS, or bone marrow disease?

__Yes __No During the past year, have you received blood, blood products, or immune globulin?

__Yes __No Have you had any vaccinations in the past 4 weeks?

__Yes __No Are you pregnant, or is there a chance you could become pregnant in the next month?

__Yes __No Have you ever been paralyzed with Guillian-Barre Syndrome?
(Guillian-Barre Syndrome is an illness with sudden muscle weakness and some loss of senses in the fingers and toes.)

INFORMATION ABOUT THE PERSON TO RECEIVE THE VACCINE:

_____/_____/_____ _____ _____

Date of Birth | Name of Primary Care Physician | Physician's Phone #

_____ (_____)_____

Name | Phone Number

_____ _____ _____ _____

Address | City | State | Zip Code

X _____

Signature of Patient or Parent/Legal Guardian (if patient is under 18)

***If this vaccine will be filed under Medicare, present your card so we may make a copy.**

By signing this form, I authorize the release of any medical or other information necessary to process this claim. I also request and authorize the payment of government benefits to the party who accepts assignment. My signature will also confirm my acknowledgement of receiving a copy of the Richard's Pharmacy Notice of Privacy Practices. If I decide to leave less than 15 minutes after the vaccine has been administered, my signature indicates that I will not hold any Richard's Pharmacy employee liable for any adverse reaction that may occur outside of their supervision.

For Pharmacy Use Only

(VIS – Inactivated Influenza – 08/15/2019) (VIS – Pneumococcal polysaccharide PPSV-23– 10/30/2019) (VIS – PCV-13 – 10/30/2019)

Date VIS was given:_____

Influenza vaccine - _____ - **Lot #**_____

Pneumonia vaccine – Pneumovax 0.5mL – **Lot #**_____ Prevnar-13- **Lot #** _____

Administration Route *(circle one)* : **IM Right Deltoid** or **IM Left Deltoid**

Expiration Date:_____

_____ Dr Desi Canals

Signature of Immunizer Authorizing Physician