VACCINE CONSENT FORM

First Name:_____ Middle Initial:_____ Last Name: _____

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

Phone: (_____)_____ Emergency Contact:_____ Phone ( ) _____

Birth date:_____/_____/_____ Age:_____ Sex: M F Primary Care Physician _____

The questions below will allow us to determine if you are eligible for a vaccine today .If any question is unclear, please ask a pharmacist for assistance.

	ALL VACCINES	YES	NO
1.	Are you sick today? If yes, ask the following questions:	_____	_____
	A. Do you have a fever?	_____	_____
	B. Do you have a cough?	_____	_____
	C. Do you have diarrhea?	_____	_____
	D. Have you been vomiting?	_____	_____
2.	Have you ever fainted on felt dizzy after receiving a vaccination?	_____	_____
3.	Have you ever had a reaction after receiving a vaccine?	_____	_____
4.	Do you have a long-term health problem with heart disease, lung disease, Asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes) or anemia or another blood disorder?	_____	_____
5.	Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	_____	_____
6.	Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, B-bovine protein, gelatin, gentamycin, neomycin, phenol, yeast or thimerosal?	_____	_____
7.	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain Barre' syndrome or other nervous system problems?	_____	_____
8.	For women: Are you pregnant or considering becoming pregnant next month?	_____	_____
9.	If 5-17 years old are you taking aspirin or any aspirin containing products?	_____	_____
10.	Have you taken any anti-virals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	_____	_____
11.	Has it been more than 10 years since your last tetanus shot?	_____	_____
12.	If you are 65 older have you had a pneumonia shot?	_____	_____

	LIVE VACCINES		
1.	Are you currently on home infusion or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia,, Arava, Actermra, Cytoxan, Rituxin, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	_____	_____
2.	Have you received any vaccinations or skin tests in the past four weeks?	_____	_____
3.	Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	_____	_____
4.	Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?	_____	_____
5.	Do you have a history of thymus disease (including myasthenia gravis), or thymectomy? (Yellow Fever only)	_____	_____
6.	Are you currently taking any antibiotics or antimalarial medications (Oral Typhoid only)	_____	_____

CONSENT FOR VACCINE ADMINISTRATION

This pharmacy is providing necessary vaccines to you in a safe and convenient setting in order to promote adherence to current immunization guidelines recommended by the CDC and ACIP. It does not take the place of an ongoing relationship with your primary care provider to address ongoing medical issues and other types of preventive care. We are providing your primary care provider with records of the vaccine(s) administered here so that your medical records may be complete, but be sure to take your personal record with you to your next appointment as well.

Please review the statement below confirming your consent for vaccination and provide the information requested.

I have read, or had explained to me, the Vaccine Information Statement for the _____ vaccine(s). I understand the risks and benefits and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I wish to receive the _____ vaccine(s) and hereby give consent for _____ (Pharmacist Name) to administer the _____ vaccine(s) and communicate the administration of the vaccine(s) to my primary care practitioner, who is listed below. I understand and agree that the company may be required by applicable law to report certain information without notice to me about my vaccination to the appropriate state and federal regulatory authorities for purposes such as reporting adverse events or immunization registries.

I further agree to hold harmless BI-LO, LLC, and its subsidiaries parent companies, officers, employees, agents, representatives, contractors, successors and assignees from any claim or action arising out of or, in any way incidental to this vaccination. I am 18 years or older, under no duress, and have read and understand this informed consent for the _____vaccine(s).

_____
Vaccine recipient's name

_____
Vaccine recipient's date of birth

_____
Vaccine Recipient's (or legal representative's) signature

_____
Date

_____
VIS

_____
Vaccine recipient’s designated primary care practitioner.

For Internal Use Only

Admin date	Vaccine	Vaccine Lot #	Exp Date	Manufacturer	Dosage	Site of Injection
						IM/SQ L/R Deltoid/PLUA
						IM/SQ L/R Deltoid/PLUA
						IM/SQ L/R Deltoid/PLUA
Signature of Pharmacist						