Vaccine Administration Consent Form

SECTION A *(Please print clearly.)*

First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender *(check one)*: Female Male

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

fred's Pharmacy **will send immunization information from this visit to your Doctor/Primary Care Provider using the contact information provided below.**

Doctor/Primary Care Provider Name: _____ Phone Number: _____

Doctor/Primary Care Address: _____ City: _____ State: _____

I consent to receive the following immunization(s) *(check all that apply):*

Hepatitis A		Hepatitis B		Human papillomavirus		Polio	
Typhoid		Flu (FluMist)		Japanese encephalitis		MMR	
Meningococcal		Pneumococcal		Rabies		Tetanus	
Chicken pox (varicella)		Shingles (zoster)					

SECTION B *(The following questions will help us determine your eligibility for vaccination today.)*

All Vaccines			
1. Is the person to be vaccinated 18 years of age or older?	Yes	No	Unsure
2. Has the person to be vaccinated had a physical examination within the past year?	Yes	No	Unsure
3. Do you feel sick today?	Yes	No	Unsure
4. Do you have any health conditions such as heart disease, diabetes or asthma? If yes, please list. _____	Yes	No	Unsure
5. Do you have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list. _____	Yes	No	Unsure
6. Have you ever had a reaction after receiving an immunization including fainting or feeling dizzy?	Yes	No	Unsure
7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?	Yes	No	Unsure
8. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	Yes	No	Unsure
9. **For women:** Are you pregnant or considering becoming pregnant in the next month?	Yes	No	Unsure
Live Vaccines (Chicken pox, FluMist, MMR, typhoid, shingles)			
10. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list. _____	Yes	No	Unsure
11. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	Yes	No	Unsure
12. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	Yes	No	Unsure
13. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	Yes	No	Unsure
14. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	Yes	No	Unsure
15. Are you currently taking any antibiotics or antimalarial medications? (Typhoid only)	Yes	No	Unsure
16. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	Yes	No	Unsure
17. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	Yes	No	Unsure
18. Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?	Yes	No	Unsure

Please describe any chronic health condition or other information you feel we should know:

_____

_____

_____

I, the undersigned, acknowledge that I voluntarily consent to the general screening and /or immunizations that I have selected on this form(s). I represent and warrant to Fred's that I am not on any medications (prescription or otherwise) and I do not have any allergies, health condition, or symptoms which would prevent me from obtaining the services on this form(s). I recognize that this general screening may not be completely accurate and is not a substitute for a physical or other services provided by a licensed physician. I have been strongly urged to discuss the results with a physician. To the fullest extent allowed by law, I, the undersigned hereby release Fred's (and it parent, affiliates, agents, suppliers, employees, officers, and directors) from and against any and all liability, connection therewith, I (on behalf of myself, my spouse, dependents, successors, and assigns) hereby agree to indemnify, defend, reimburses and hold harmless Fred's (and its parent, affiliates, agents, suppliers, employees, officers, and directors) from and against any and all costs (including court costs and attorney's fees), damages, suits, actions, demands and liability associated with or arising from (1) any misstatements or omissions on any form I provided to Fred's and/or (2) my receipt of any testing, screening, and/or immunization from Fred's.

Patient signature: _____ **Date:** _____

(Parent or guardian, if minor)