

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 its 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, reimburse 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)