EXPRESS PHARMACY Vaccine Administration Record and Informed Consent

Section A (please print clearly) Pharmacist Verification: Patient Name: Patients DOB:

First Name: _____ Last Name: _____ Gender: Female Male Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____ Phone Number:

Race: American Indian/Alaskan Native Asian Black/African American White Native Hawaiian/other Pacific Islander Other Decline to state

Ethnicity: Hispanic/Latino Not Hispanic or Latino Decline to State

Do you have a Primary Care Physician? ' YES NO Primary Care Physician Name: _____ street Name _____

Do you authorize this pharmacy to send your information to your Primary Care Physician? Yes No

Vaccine Requested: Flu COVID-19 Pneumococcal Shingles Tdap Td MMR HepA HepB Meningococcal varicella HPV

Section B Questions (1-7) pertain to all vaccines and will help us determine your eligibility to be vaccin*ated today* Pharmacist Verification of DURs

1. Is the person to be vaccinated sick or injured today? if Yes,		NO
a. Does the person have a new of moderate to high fever	YES	NO
b. Does the person n have a cough?	YES	NO
c. Does the person have diarrhea?	YES	NO
d. Has the person been vomiling7	YES	NO
e. Do you have a cut, injury, puncture, or open wound that prompted you to get a tetanus shot?	YES	NO
Pharmacist Initials after reviewing with patient:	YES	
2. Does the person to be vaccinated have allergies to medications, food components, vaccine components, or latex7 If yes, please list. Example: eggs, bovine protein, gelatin, gentamycin, polymyxin, neomycin, *phenol, yeast, thiomersal*	YES	NO

3. Does the person to be vaccinated have a chronic health condition or Long term health problem?
YES NO
Examples: heart, lung, kidney, neuromuscular Liver metabolic diseases, asthma, diabetes, anemia, other blood disorders, neurologic or is the patient a smoker?

4. Has the person to be vaccinated ever had a reaction, fainted, or felt dizzy after receiving a vaccine or has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	YES	NO
5. Has the person to be vaccinated ever had a seizure disorder for which they are on seizure medications, a brain disorder, Gillian- Barre Syndrome, or other nervous system problems?	YES	NO
6. Is the person to be vaccinated currently pregnant, considering becoming pregnant in the next month, or breast-feeding?	YES	NO
7. Does the person to be vaccinated have a weakened immune system, is in contact with anyone with a severely weakened immune system or In long-term treatment with drugs such as high-dose steroids? E*xamples: cancer , leukemia, lymphoma, HIV/Aids, transplant, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease* or any order immune system disorder?	YES	NO
If the person is receiving COVID-19 vaccines		
8. Has the person to be vaccinated received any vaccinations or skin tests in the past four weeks?	YES	NO
9. Is the person to be vaccinated currently on home infusions, weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Slmponl, Simponi Aria, Xelianz, Orencia, Arava, Actermra, Cytoxin, Rituxan, adalimumab, infliximab or etanercept, high dose methotrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or radiation treatment,cortisone or high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?	YES	NO
10. Has the person to be vaccinated received antibodies, a transfusion of blood or blood products, been given immune (gamma) globulin, or antivirals in the past year?	YES	NO
11. Does the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II only)?	YES	NO

Section C: Please read the section below carefully and sign and date acknowledging that you understand and agree.

I hereby give my consent to Express Pharmacy, as applicable, to administer the medications(s) I have requested above. I understand the benefits and risks of receiving this medication and have received, read and/or had explained to me the Vaccine Information Statement and/or Vaccine Patient Fact sheet for the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I fully release and discharge Express Pharmacy, its staff, agents, successor, division, affiliates, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccines listed above. Initials: _____

I understand, acknowledge, and consent that the administration of this vaccine will be entered into my state's immunization registry. I understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state law, I may prevent disclosure of my immunization to the state registry with a signed Opt-Out. The Pharmacist has informed me that I may have the right to refuse. I acknowledge that the administration of this vaccine will be reported to any required local, state, or federal health authorities. Initials: ___

I assign payment of authorized insurance benefits due to me to be paid to the pharmacy. I consent to the release of medical information when necessary for billing, reimbursement, arid medical protocol. Initials: ___

I am aware a pharmacist, qualified pharmacy technician or state authorized pharmacy intern, as allowed by law, might be administering this medication. initials: _

Patient/Legal Guardian Name: _____ Signature: Date:

Section D: The following section is to be completed by a healthcare provider ONLY.

Pharmacist Name (print): _____ Pharmacist Signature: _____

Administering individual Name and Title (Print): _____ Administration Date/Date VIS Given: _____

Vaccine	Lot#	Exp. Date	Manufacturer	NDC	Dosage Site	Route	VIS Date	RPh Initials
						LA RA SQ IM		
						LA RA SQ IM		