Flu Shot

Access Pharmacy & Medical Equipment

Vaccination Administration Record
Informed Consent

First Name:_____ MI:____ Last Name:_____ DOB: _____ Gender: _____

Address: _____ City: _____ State:_____

_____ Zip Code: _____ Phone #: _____

The following questions will help us determine your eligibility to be vaccinated today.	YES	NO	UNSURE
1. Do you have fever, diarrhea or have you vomited today?			
2. Do you have allergies to medications, foods, or any vaccine?			
3. Have you ever had a serious reaction after receiving any vaccination?			
4. Have you ever had a seizure disorder, brain disorder, Guillain-Barre Syndrome?(a condition that causes paralysis) or any other nervous system problems?			
5. Do you have immune system problems, cancer, leukemia, lymphoma, or HIV/AIDS?			
6. Are you currently on home infusions, weeky injections, and/or taking medications such as Remicate®, Humira®, or Kineret®? **Please refer to your Pharmacist if you are unsure of this.**			
7. Do you take cortisone, prednisone, other steroids, anticancer drug or have had x-ray treatments?			
8. Have you received a transfusion of blood or any blood products, or been given a medicine called immune (gamma) globulin in the past year?			
9. Have you received any vaccinations in the past 4 weeks?			
10. **WOMEN**: Are you pregnant or considering becoming pregnant in the next month?			
11. **AGES 65 YEARS OF AGE OR OLDER**: Have you ever had a pneumococcal or "Pneumonia" vaccination?			

I certify that I am: I the Patient and at least 18 years of age; II the parent or legal guardian of the minor Patient who is at least 9 years of age or older as required by state law; or III the legal guardian of the Patient. Further, I hereby give my consent to the pharmacist of Access Drugs, LLC to administer the vaccine(s) that I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read, and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering pharmacist. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Access Drugs, LLC, its staff, agents, successors, divisions, affiliates, subsidiaries, offices, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I authorize Access Drugs, LLC to release any medical or other information to health care professionals, Medicare, Medicaid, or other third party payor necessary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Access Drugs, LLC with respect to the vaccine(s) listed above.

Signature: _____ **Date:** _____
(Person receiving vaccine(s) or Parent or Guardian, if recipient is a minor)

Pharmacy Use Only:

Immunizer Name (print): _____ RPh/PharmD

Immunizer Signature: _____ RPh/PharmD

Intern Name (if applicable): _____

Vaccine Administration Date: _____ Date VIS Given to Recipient: _____

Vaccine	Lot #	Exp. Date	Maufacturer	Dosage	Site of Injection	VIS Date	Date PNL Sent