



Immunization Consent Form

PHARMACY USE ONLY:

UPDATED STATE REGISTRY NOTIFIED PHYSICIAN Rx # _____

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	VACCINE REQUESTED	
ADDRESS	CITY		STATE	ZIP
10-DIGIT PHONE NUMBER	GENDER (M/F)	BIRTH DATE (MM/DD/YYYY)		INSURANCE ID NUMBER
PRIMARY CARE PHYSICIAN	PHYSICIAN'S ADDRESS		PHYSICIAN'S PHONE/FAX	

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each questions.)

- | | | | |
|--|--|---|--|
| 1. Are you sick today?.....
If yes, specify symptoms: _____ | <input type="radio"/> YES <input type="radio"/> NO | 9. Are you currently on home infusions or weekly injections?
If yes, which medications? _____ | <input type="radio"/> YES <input type="radio"/> NO |
| 2. Do you have allergies to medications, food or vaccines?
If yes, list: _____ | <input type="radio"/> YES <input type="radio"/> NO | 10. Have you received any vaccinations or skin test in the past 4 weeks?
If yes, what vaccinations? _____ | <input type="radio"/> YES <input type="radio"/> NO |
| 3. Have you ever had a serious reaction after receiving a vaccination?..... | <input type="radio"/> YES <input type="radio"/> NO | 11. Are you allergic to eggs?..... | <input type="radio"/> YES <input type="radio"/> NO |
| 4. Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders? | <input type="radio"/> YES <input type="radio"/> NO | 12. Are you allergic to latex?..... | <input type="radio"/> YES <input type="radio"/> NO |
| 5. Have you ever felt faint or dizzy after receiving a vaccine? | <input type="radio"/> YES <input type="radio"/> NO | 13. For Women: Are you pregnant or is there a chance you could become pregnant during the next 3 months? | <input type="radio"/> YES <input type="radio"/> NO |
| 6. Do you have cancer, leukemia, AIDS, or any other immune system problems? | <input type="radio"/> YES <input type="radio"/> NO | 14. In the past 3 months, have you or anyone in your household taken cortisone, prednisone, other steroids, high-dose methotrexate, azathioprine, 6-mercaptopurine, antivirals, anticancer drugs, or have you had any radiation treatments? | <input type="radio"/> YES <input type="radio"/> NO |
| 7. Have you had Guillain-Barre Syndrome, a seizure, brain or nerve problem? | <input type="radio"/> YES <input type="radio"/> NO | | |
| 8. During the past year have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? | <input type="radio"/> YES <input type="radio"/> NO | | |

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection. Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunizations. These reactions may result from hypersensitivity reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations. In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

ADMINISTRATIVE RECORD FOR PHARMACY USE ONLY

VACCINE: _____	EXPIRATION DATE: _____	VACCINE: _____	EXPIRATION DATE: _____	VACCINE: _____	EXPIRATION DATE: _____
VIS VERSION: _____	SITE OF INJECTION: _____	VIS VERSION: _____	SITE OF INJECTION: _____	VIS VERSION: _____	SITE OF INJECTION: _____
MANUFACTURER: _____	DOSAGE: _____	MANUFACTURER: _____	DOSAGE: _____	MANUFACTURER: _____	DOSAGE: _____
LOT NUMBER: _____	ROUTE OF ADMIN: _____	LOT NUMBER: _____	ROUTE OF ADMIN: _____	LOT NUMBER: _____	ROUTE OF ADMIN: _____

PAYMENT INFORMATION FOR PHARMACY USE ONLY

VACCINE FEES _____ TOTAL CHARGE _____

"I have read the adverse reactions associated with the administration of vaccines. A copy of the vaccine information sheet has been provided to me and a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian ("WARD"). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my injury, death or damaged suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Hawthorne will use and disclose your personal and health information or personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices."

SIGNATURE / LEGAL GUARDIAN

DATE OF VACCINATION / DATE VIS GIVEN

PRINT NAME

PHARMACIST NAME / LICENSE #

PHARMACIST ADDRESS / PHONE #

PLEASE PROVIDE A COPY OF THIS FORM TO YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER FOR YOUR PERMANENT MEDICAL RECORDS.

WHITE - ADMINISTRATIVE COPY YELLOW - PATIENT COPY