

## IMMUNIZATION CONSENT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Primary Physician (If known) \_\_\_\_\_

**MEDICARE RECIPIENTS:** (We will need a copy of your card)

Do you have a Medicare Advantage plan?  Yes  No

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Store or Location: \_\_\_\_\_ Are you a dependent?  Y  N

**Flu:** Quadrivalent (4 strain)  Fluzone® High-Dose (65+)  Flublok® (preservative/egg free extra protection)

**C`XYf`5 Xi `rg.`**  Prevnar 13  Pneumovax 23  Shingles

**5 Xc`YgWbbrg`UbX`nci b[ `5 Xi `rg.`**  HPV  Meningitis (MCV4)  Meningitis B

**Fci h`bY.**  Td (tetanus)  Hep A  Hep B  Hep A & B  MMR  Varicella  Polio  Rabies

**: Ua ]Yg`k ]h `VU]Yg`cf`W`bH`W`k ]h `nci b[ `W ]Xf`Yb.**  Tdap (whooping cough)

**HfUj`Y.**  Yellow Fever  Typhoid (oral)  Typhoid (shot)  Japanese Encephalitis  Cholera

**K cf`\_.**  TB skin test  CH`Yf. \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE:**

- Yes  No Have you ever had an allergy or serious reaction to latex, eggs, vaccines or any medications?  
If yes please specify allergy or reaction: \_\_\_\_\_
- Yes  No Do you have any long term health conditions or smoke? Please list conditions: \_\_\_\_\_
- Yes  No Do you weigh less than 66 lbs?
- Yes  No If you are diabetic, have you received the hepatitis B series of vaccinations?
- Yes  No **For WOMEN:** Are you currently breastfeeding, pregnant or planning to become pregnant in the next month?
- Yes  No If you are over 65 years of age have you received **BOTH** pneumonia vaccines?
- Yes  No If you are over 50 years of age have you received a shingles vaccine?
- Yes  No Have you had any **LIVE** vaccinations in the past 4 weeks? (ex: MMR, Varicella, Shingles, FluMist or Yellow Fever)
- Yes  No Have you taken an antiviral medication within the past 48 hours? (i.e. Tamiflu, Valtrex, Famvir, acyclovir)
- Yes  No Are you currently taking any medications that may thin the blood and increase bleeding?
- Yes  No Have you experienced a fever (>100.5), nausea, vomiting or diarrhea within the past 24 hours?
- Yes  No Are you currently taking steroid therapy, chemotherapy, radiation treatments, or medications for rheumatoid arthritis?

I verify I have answered the questions above accurately and to the best of my knowledge. I have been provided access to a copy of United Supermarket Pharmacy's Notice of Privacy Practices & the Vaccine Information Statement for the vaccine(s) I will receive today. I understand the benefits and risks of receiving this immunization, and have been given the opportunity to ask any questions. I hereby release United Supermarkets, LLC, and all officers, directors and employees from any and all liability arising from or in any way connected with this immunization. I understand that my receipt of this vaccination is subject to reporting, by my pharmacy or its business associate, to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Dept. of Health, if applicable, and I authorize these disclosures. I hereby request that the above named immunization(s) be given to me or to the person named above for whom I am authorized to sign.

Signature \_\_\_\_\_ Date \_\_\_\_\_



CLINIC: \_\_\_\_\_ PRICE MODIFY:  Y  N

FOR PHARMACY USE ONLY				
Medicare #: _____				
PAID: \$ <input type="checkbox"/> Cash <input type="checkbox"/> Credit <input type="checkbox"/> Account				
Vaccine	Lot	Exp	Site	VSDA/IE
1 <sup>st</sup> :			R/L	
2 <sup>nd</sup> :			R/L	
3 <sup>rd</sup> :			R/L	
4 <sup>th</sup> :			R/L	
5 <sup>th</sup> :				
Administered by: _____				