



Immunization Consent Form

Name: _____ Date of birth: ___/___/___ Age: _____ Medicare ID: (including alpha) _____
 Home address: _____ City: _____ State: _____ ZIP code: _____
 Gender: M / F Phone: (____) _____ Emergency Contact: _____ Phone: (____) _____
 Email address: _____ Doctor / primary care provider name: _____

Precautions and Contraindications: Please answer each question

| | | | | |
|-----------------------------------|---|------------------------------|-----------------------------|-------------------------------------|
| Vaccination Assessment | Do you have heart disease, lung disease, asthma, kidney disease, liver disease, diabetes, or smoke cigarettes? (Pneumovax) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Do you have asplenia, CSF leaks, or an immunocompromising condition (e.g. HIV/AIDS, cancer, leukemia, lymphoma, transplant, multiple myeloma, renal failure, nephrotic syndrome)? (Pneumovax) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Are you taking any immunocompromising drugs (e.g. steroids or drugs for cancer, transplant, Crohn's, ulcerative colitis, psoriasis, rheumatoid arthritis, multiple sclerosis)? (Pneumovax) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Are you at least 65 years old? (Pneumovax) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Are you pregnant or in close contact with any newborn children? (Tdap – third trimester) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Has it been more than 10 years since your last Tetanus shot? (Tdap) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Are you at least 50 years old? (Shingrix) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Do you plan to travel outside of the United States in the next year? (Online Travel Form) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Inactive and Live Vaccines | Are you currently sick with a moderate to high fever, vomiting/diarrhea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Have you ever fainted or felt dizzy after receiving an immunization? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Have you ever had a reaction after receiving an immunization? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Have you ever had a seizure disorder, a brain disorder, Guillain-Barré syndrome or other nervous system problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, list: _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| Live Vaccines Only | Do you have an immunocompromising condition or take an immunocompromising drug (see above)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Are you currently taking antivirals or high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Have you received any vaccinations or skin tests in the past 4 weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | For women: Are you pregnant or considering becoming pregnant in the next month? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Do you have a history of thymus disease (including myasthenia gravis), thymoma or prior thymectomy? (Yellow fever only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| | Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

I want to receive the following immunization(s): _____

Directions: Administer each immunization listed above as directed

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Cheek and Scott Drugs, Inc., to administer the vaccine(s) 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 healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Cheek and Scott Drugs, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, 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 acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) Cheek and Scott Drugs, may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, a Cheek and Scott Drugs opt-out form ("Opt-Out Form"): (a) the disclosure of my immunization information by Cheek and Scott Drugs to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my immunization information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. Cheek and Scott Drugs will, if my state permits, provide me with an Opt-Out Form upon request. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to Cheek and Scott Drugs reporting my immunization information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide Cheek and Scott Drugs with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to Cheek and Scott Drugs and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information to or through the State HIE as required or permitted by law. I also authorize Cheek and Scott Drugs to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) proof of immunization to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize Cheek and Scott Drugs to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to Cheek and Scott Drugs with respect to the above requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if Cheek and Scott Drugs invoices me after the time of service, upon receipt of such invoice.

Signature of Patient or Legal Guardian _____ Relation to Patient _____ Date _____

For Pharmacy Personnel Only

| Vaccine Type | Vaccine | | | Date Given (mo/day/yr) | Route (IM, SQ) | Site Given (RA, LA) | Vaccine Information Statement | |
|--------------|---------|------------|--------------|------------------------|----------------|---------------------|-------------------------------|------------|
| | Lot # | Expiration | Manufacturer | | | | Date on VIS | Date Given |
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Printed Name of Immunizing Pharmacist _____ Pharmacist Signature _____ Per Immunization Protocol Developed By Dr. A.C. Bass