

VACCINE CONSENT FORM

PLEASE READ AND FILL OUT THIS FORM COMPLETELY BEFORE SIGNING

RISKS AND POSSIBLE SIDE EFFECTS OF VACCINATION.

PLEASE CHECK OFF EACH STATEMENT AFTER YOU READ IT.

- Side effects of vaccines are generally mild
- The most common side effect of vaccination is soreness at the vaccination site
- Other side effects include fever, tiredness, muscle pain, and rarely, allergic reactions.
- As is the case with most drugs & vaccines, there is a chance that a serious allergic reaction, illness, or even death could occur as a result of vaccination.

BEFORE YOU GET VACCINATED, COMPLETE THIS CHECKLIST BY CHECKING OFF YES OR NO FOR EACH SITUATION THAT APPLIES TO YOU. PLEASE REVIEW EACH ANSWER WITH THE PRACTITIONER GIVING YOU THE VACCINE.

- Yes NoI am pregnant or expect to be pregnant in the near future.
- Yes NoI am allergic to eggs or egg products, thimerosal, or a component of the vaccine.
- Yes No.....I have had a reaction after receiving a previous vaccination
- Yes No.....I have developed a neurological illness (such as Guillain-Barre syndrome) after a vaccine.
- Yes No.....I have received another type of vaccine within the past 4 weeks
- Yes No.....I have a low platelet count, a coagulation disorder, or am on anticoagulant therapy.
- Yes No I have an acute illness with fever.
- Yes No I am immune-compromised (due to therapy or a disease)

IF YOU CHECKED YES TO ANY OF THE ABOVE ITEMS OR IF YOU ARE UNSURE ABOUT YOUR MEDICAL HISTORY, TALK TO YOUR HEALTHCARE PROFESSIONAL BEFORE GETTING VACCINATED AND BEFORE YOU SIGN THIS FORM. No vaccine may protect 100% of persons who are vaccinated.

Consent: I have read the information on this form about my vaccine. I have had an opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of flu vaccination as described and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request. I have been given a copy of the vaccine information sheet published by the Centers for Disease Control and Prevention (CDC). **I UNDERSTAND I HAVE BEEN ADVISED TO STAY AT THE PHARMACY FOR 20 MINUTES FOLLOWING MY VACCINE.**

Information concerning person to receive vaccine: VIS(S) PUBLICATION DATE _____

TETANUS DIPHTHERIA PERTUSSIS HEPATITIS HPV MENINGITIS HERPES ZOSTER INFLUENZA PNEUMONIA

NAME PRINTED _____ SIGNATURE _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Physician _____ PERSON GIVING VACCINE _____ DATE _____ SITE _____

LOT# _____ EXP.DATE _____ MANUFACTURER _____