Giant Pharmacy
Vaccine Informed Consent Form

Name: ______________________ Date of Birth: __/__/__ Male/Female: ________

Street Address: ______________________ City: __________ State: ____ Zip: ________

Phone: ______________________ Medicare B # : ______________________ Age: ________

Primary Physician: ______________________ Physician Address: ______________________

Vaccine(s) to be given today: ______________________ ______________________

The following questions will help us determine your eligibility to be vaccinated today. If any questions are unclear, please ask for assistance.

		YES	NO
1.	Do you feel sick today or currently have a fever or infection?	______	______
2.	Are you allergic to any drugs, foods, or vaccines? (i.e. eggs, Baker's yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, Bovine protein)	______	______
3.	Have you ever had a severe reaction to any vaccine which required medical care?	______	______
4.	Have you had a seizure, brain or any other neurological disorder or have you had Guillain-Barré Syndrome, a condition which causes paralysis?	______	______
5.	Have you had Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?	______	______
6.	Have you taken any anti-virals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	______	______
7.	Are you, anyone in your home, or anyone you take care of being treated with prednisone, other steroids, weekly injections, anticancer drugs or radiation?	______	______
8.	Do you, anyone in your home, or anyone you take care of have cancer, HIV/AIDS or any other immune deficiency disorder?	______	______
9.	If 5-17 years of age: Are you currently taking aspirin or any aspirin-containing products?	______	______
10.	For women: Are you pregnant or planning a pregnancy in the next 3 months?	______	______
11.	Have you received any vaccinations in the past 4 weeks?	______	______
12.	Has it been more than 10 years since your last tetanus shot?	______	______
13.	There are now two recommended pneumonia vaccines. If you are 65 or older, have you had a pneumonia shot since September 2014?	______	______
14.	If you are 50 or older, have you had a shingles shot since January 2018?	______	☐
15.	Do you have children you would like to protect against the flu? *(Childhood vaccinations not offered in all states)*	______	______

16. You may need other immunizations for your protection. **Circle** each condition below that applies so we may screen you for other needed vaccines to keep you healthy.

Diabetes Asthma Smoker Heart condition Lung condition 50 or older

I certify that I am at least 18 years old and hereby give my consent to the staff of Giant Pharmacy to administer the vaccine (s) listed below. I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked below. I authorize the information to be forwarded to my primary care physician, authorizing physician or local Dept. of Health if applicable. **I agree to stay in the general area for 20 minutes after receiving my vaccination in case any immediate reactions occur**. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Giant Pharmacy and its parent, subsidiary and affiliates, and its officers, employees and agents, respectively, from any and all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives.

X ______________________ Date __/__/__ I would like a copy of this completed consent. ☐

Signature of Patient or Patient's Personal Representative

A Personal Representative is someone who has legal authority to make healthcare decisions on behalf of the patient

Admin. Date	Vaccine	Vaccine Lot#	Exp Date	Manufacturer	Dosage	Site of Injection	VIS Date
						IM/SQ L/R Deltoid/PLUA	
						IM/SQ L/R Deltoid/PLUA	
						IM/SC L/R Deltoid/PLUA	
Signature of Pharmacist/Title:						**RPh**	

*PLUA- Post-lateral upper arm (SQ), Deltoid (IM)