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 Guillain-Barré Syndrome, a condition which causes paralysis?	_____	_____
5.	Do you have a history of seizures or any other brain disorders?	_____	_____
6.	Have you had Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?	_____	_____
7.	Have you taken any anti-virals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	_____	_____
8.	Are you, anyone in your home, or anyone you take care of being treated with prednisone, other steroids, weekly injections, anticancer drugs or radiation?	_____	_____
9.	Do you, anyone in your home, or anyone you take care of have cancer, HIV/AIDS or any other immune deficiency disorder?	_____	_____
10.	If 5-17 years of age: Are you currently taking aspirin or any aspirin-containing products?	_____	_____
11.	For women: Are you pregnant or planning a pregnancy in the next three months?	_____	_____
12.	Have you received any vaccinations in the past 4 weeks?	_____	_____
13.	Has it been more than 10 years since your last tetanus shot?	_____	_____
14.	There are now two recommended pneumonia vaccines. If you are 65 or older, have you had a pneumonia shot since September 2014?	_____	☐
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 _____ / /

Patient Signature (Parent or Guardian, if minor) **Date**

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:							

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