COMMUNITY
HEALTH
ALLIANCE

Vaccine Informed Consent

Patient Information

First Name: ______________________________ Last Name: _______________________________

Date of Birth: ______________________________ Primary Care Provider: _____________________

Address: ____

____

Home Phone: ___________________________ Cell Phone: _______________________________

Insurance Information

Insurance Name: ___________________________ Insurance ID Number: _________________________

Insurance Group Number: ____________________

I, the undersigned, have read or had explained to me the vaccination information sheet (VIS). I understand the risks and benefits associated with the vaccine(s) and have had my questions answered to my satisfaction. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request.

☐ I authorize the vaccine(s) to be administered by a trained student pharmacist.

Signature: ____ Date: ____________________

Print name of parent, guardian or caregiver: ____

Vaccine History			
	Yes	**No**	**Unknown**
How long has it been since your last TETANUS SHOT?	_____ years		
Do any of the following apply to you? Asthma Diabetes Heart Disease Tobacco Smoker Age 65 or older	☐	☐	☐
If you checked yes to the above question, have you ever received the PNUEMOCOCCAL vaccine? – If yes, when? _____	☐	☐	☐
Patients age 50 or older: – Have you ever received the SHINGLES vaccine?	☐	☐	☐
Screening Questionnaire			
Are you currently ill or do you have a fever?	☐	☐	☐
Have you ever received the flu vaccine before?	☐	☐	☐
Have you ever had a serious reaction to a vaccine before?	☐	☐	☐
Are you allergic to latex or rubber?	☐	☐	☐
Are you allergic to eggs or any other components of the vaccine?	☐	☐	☐
Do you have a blood-clotting disorder?	☐	☐	☐
Have you ever had Guillain-Barre Syndrome?	☐	☐	☐
For women: – Are you currently pregnant?	☐	☐	☐
Live Vaccines (MMR, Varivax, Others)			
Have you received any vaccines in the past month? – If yes, which ones? ________________________	☐	☐	☐
Do you have any disease that affects the immune system (cancer, HIV, transplant, etc)?	☐	☐	☐
Are you currently receiving Humira Remicade, Enbrel, methotrexate, azathioprine, 6-mercaptopurine, antivirals, steroids, anticancer or radiation therapy?	☐	☐	☐
In the last year, have you received a blood transfusion or blood products?	☐	☐	☐
In the last year, have you had radiation therapy?	☐	☐	☐

Pharmacy Use Only					
Vaccine Name					
Lot					
Expiration					
Manufacturer					
Dose					
Route (IM/SQ)					
Site (RD, LD, RA, LA)					

Signature of Pharmacist/Provider: ________________________________ Date: ____________

☐ Entered into WebIZ

Funding: ☐ 317 ☐ VFC ☐ Private

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