FAGEN PHARMACY

VACCINATION CONSENT & RELEASE FORM

Name:	**Date of Birth:**
Address:	**Sex:** (circle one) **Male Female**
City/ State/ Zip:	**Primary Care Doctor:**
Phone:	**Doctor's City/State:**
Medicare number:	**Medicare letter:**

Circle requested vaccine: **Flu Shot (Tri - Quad - HD) Meningitis Pneumonia Shingles Tetanus**

CONSENT: For ALL vaccines answer questions 1-8. For SHINGLES answer questions 1-13.	**Yes**	**No**	**Don't know**
1. Do you feel **sick** today and/or have a fever?			
2. Do you have any **allergies** to latex, food, medications, or any vaccine? (Especially: Eggs, Gelatin, Gentamicin, Polymyxin, Neomycin, Phenol, Thimerosal, or Bovine Protein) *If YES, please list allergies:*			
3. Have you ever had a **serious reaction** to the flu shot or any other vaccine in the past?			
4. Have you received **any** vaccination in the last 4 weeks? If yes, please list:			
5. Have you ever had a **seizure** disorder for which you are on seizure medications or had **Guillian-Barre Syndrome** (a condition that causes paralysis)?			
6. For women: are you currently **pregnant** or considering becoming pregnant?			
7. Are you over the age of 65 **or** do you smoke **or** do you have a chronic condition (asthma/ diabetes/ heart condition)?			
8. If you answered yes to #7, have you ever had a **pneumonia** vaccination? If yes, when:			
9. Do you have a **weakened immune system** due to HIV/AIDS, another disease that affects the immune system, or cancer treatment such as radiation or chemotherapy?			
10. Are you taking Enbrel, Humira, Kineret, Remicade, or on home infusions or weekly injections?			
11. Are you taking immunosuppressive therapy or **oral steroids** (prednisone, cortisone, etc.)			
12. Do you have active tuberculosis (**TB**)?			
13. Have you had **shingles** in the past? If yes, when:			

I have received and read the Vaccine Information Statement by the Centers for Disease Control and Prevention. I wish to receive the vaccine requested above, and have had an opportunity to ask questions which were answered to my satisfaction. I have had full opportunity to read and consider the Privacy Practices Notice of Fagen Pharmacy, Inc. to my satisfaction prior to consent. I accept that services might be rendered in a non-private setting. I understand the benefits and risks of the requested vaccine and I hereby consent to the administration of the indicated vaccine. I elect to participate fully in, and consent to Fagen Pharmacy reporting my immunization information to the state's immunization registry, unless I complete a state approved opt-out process. I also consent Fagen Pharmacy to communicate my vaccination(s) to my primary care provider. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, advisory committees from any and all claims, demands, actions and causes of action, which may result from participation in this program.

Signature: _____ **Date:** _____

(or parent/guardian consent if age<18)

For Pharmacist Use: Immunizer:_____

Vaccine	Manufacturer	VIS Date	Dosage	Site	Lot #	Exp Date	Date PNL Sent	Chirp
FLUVIRIN-IIV3	Novartis	08/07/15	0.5 ml	L / R Deltoid IM				
PNEUMOVAX	Merck	04/24/15	0.5 ml	L / R Deltoid IM				
ZOSTAVAX	Merck	10/06/09	0.65 ml	L / R Arm SC	Diluent:	Diluent:		
ADACEL (Tdap)	Sanofi Pasteur	02/24/15	0.5 ml	L / R Deltoid IM				
MENACTRA	Sanofi Pasteur	10/14/11	0.5 ml	L / R Deltoid IM				