

# QUALITY CARE PHARMACY

## IMMUNIZATION CONSENT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First MI MM/DD/YYYY

Address: \_\_\_\_\_ Sex:  M  F  
Street/P.O. Box City State Zip

Phone: (\_\_\_\_) \_\_\_\_\_ Primary Physician (If Known): \_\_\_\_\_ Do you weigh less than 66 lbs?  Yes  No

**MEDICARE RECIPIENTS: (We will need a copy of your card)**

Do you have Medicare Part B?(red, white & blue card)  Yes  No  
 Do you have a Medicare Advantage plan?  Yes  No

**PLEASE INDICATE WHICH VACCINE(S) YOU WILL RECEIVE TODAY:**

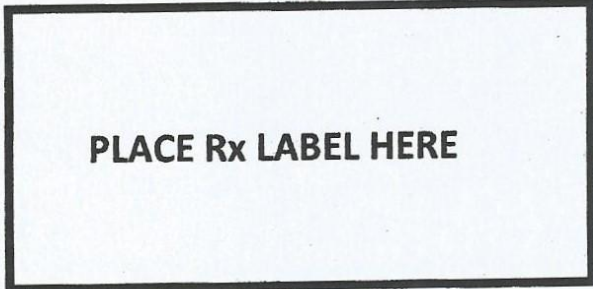
- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> Flu (Reg, HD, Quad)     | <input type="checkbox"/> Flumist           | <input type="checkbox"/> TB skin test            | <input type="checkbox"/> Pneumonia (Pneumovax®)   | <input type="checkbox"/> Shingles (Zostavax®) |
| <input type="checkbox"/> Tetanus (Td, Tdap)      | <input type="checkbox"/> Hepatitis A       | <input type="checkbox"/> Hepatitis B             | <input type="checkbox"/> Hepatitis A/B (Twinrix®) | <input type="checkbox"/> Meningitis           |
| <input type="checkbox"/> Oral Typhoid (Vivotif®) | <input type="checkbox"/> Typhoid (Typhim®) | <input type="checkbox"/> Inactivated Polio (IPV) | <input type="checkbox"/> Yellow Fever (YF-Vax®)   | <input type="checkbox"/> MMR                  |
| <input type="checkbox"/> Other: _____            | <input type="checkbox"/> HPV               | <input type="checkbox"/> Japanese Encephalitis   |   |   |

**PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE:**

- Yes  No Have you ever had an allergy or serious reaction to latex, eggs, vaccines or any medications?  
 If Yes Please Specify allergy or reaction: \_\_\_\_\_
- Yes  No Have you received a Tdap (recommended as part of childhood series and as a 1 time dose for all adults over 18)?
- Yes  No If you are diabetic, have you received the hepatitis B series of vaccinations? (recommended for <60 years of age)
- Yes  No For WOMEN: Are you currently breastfeeding, pregnant, or planning to become pregnant in the next month?
- Yes  No If you are over 65 years of age or have a chronic health condition, have you received a pneumonia shot?
- Yes  No If you are over 60 years of age, have you received a shingles vaccine?
- Yes  No Have you had any LIVE vaccinations in the past 4 weeks? (ex: MMR, Varicella, Shingles, FluMist® or Yellow Fever)
- Yes  No Have you taken an antiviral medication within the past 48 hours? (i.e. Tamiflu®, Valtrex®, Famvir®, acyclovir)
- Yes  No Are you currently taking any medications that may thin the blood & increase bleeding? (i.e. ibuprofen, aspirin, warfarin, Plavix®)
- Yes  No Have you experienced a fever (> 100.5), nausea, vomiting, diarrhea, or generally "feeling bad" within the past 24 hours?
- Yes  No Are you currently taking steroid therapy, chemotherapy, radiation treatments, or medications for rheumatoid arthritis?
- Yes  No Do you have any long term health condition? (Please Circle: Diabetes, Asthma, COPD, Chronic Bronchitis, Cancer, AIDS, HIV, Rheumatoid Arthritis, Heart Disease, Organ transplant, smoking) Other: \_\_\_\_\_

I verify I have answered the questions above accurately and to the best of my knowledge. I have been provided access to a copy of United Supermarket Pharmacy's Notice of Privacy Practices & the Vaccine Information Statement for the vaccine(s) I will receive today. I understand the benefits and risks of receiving this immunization, and have been given the opportunity to ask any questions. I hereby release United Supermarkets, LLC, and all officers, directors and employees from any and all liability arising from or in any way connected with this immunization. I hereby request that the above named immunization(s) be given to me or to the person named above for whom I am authorized to sign.

Signature \_\_\_\_\_ Date \_\_\_\_\_



CLINIC: \_\_\_\_\_ PRICE MODIFY:  Y  N

**FOR PHARMACY USE ONLY**

Medicare #:				
PAID: \$ <input type="checkbox"/> Cash <input type="checkbox"/> Credit <input type="checkbox"/> Account				
Vaccine	Lot	Exp	Site	VIS Date
1 <sup>st</sup> :			R/L	
2 <sup>nd</sup> :			R/L	
3 <sup>rd</sup> :			R/L	
4 <sup>th</sup> :			R/L	
For Injection Series:	Dose #1	Dose #2	Dose #3	
Date:				
Administered by: _____				6/2014