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:

☐ Flu (Reg, HD, Quad)	☐ Flumist	☐ TB skin test	☐ Pneumonia (Pneumovax®)	☐ Shingles (Zostavax®)
☐ Tetanus (Td, Tdap)	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis A/B (Twinrix®)	☐ Meningitis
☐ Oral Typhoid (Vivotif®)	☐ Typhoid (Typhim®)	☐ Inactivated Polio (IPV)	☐ Yellow Fever (YF-Vax®)	☐ MMR
☐ Other: _____		☐ HPV	☐ 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 _____

PLACE Rx LABEL HERE

CLINIC: _____ PRICE MODIFY: ☐ Y ☐ N

FOR PHARMACY USE ONLY

Medicare #:
PAID: $ ☐ Cash ☐ Credit ☐ Account

Vaccine	Lot	Exp	Site	VIS Date
1st:			R/L	
2nd:			R/L	
3rd:			R/L	
4th:			R/L	
For Injection Series: Date:	Dose #1	Dose #2	Dose #3	

Administered by: _____ 6/2014