Vaccine Administration Consent Form

Section A (Please print clearly)

First name: ______________________________ Last name: ______________________________

Age: _______ Date of birth: ________________ Gender (check one): ☐ Female ☐ Male ☐ Non-binary

Race (check one): ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/ Pacific Islander

Ethnicity: ☐ Hispanic ☐ non-Hispanic

Home address: ____

City: ______________________________ State: _______ ZIP Code: ________________

Email address: ____

Phone number: ______________________________

Primary care physician name: ______________________________ Phone number: ______________________________

Physician fax: ______________________________

Please check the vaccinations you wish to receive today:

☐ Seasonal Influenza ☐ Hepatitis B ☐ Pneumococcal ☐ Meningococcal

☐ COVID-19 ☐ Chickenpox (varicella) ☐ Tetanus/Tdap ☐ MMR

☐ Hepatitis A ☐ HPV ☐ Shingles (zoster) ☐ Other: ______________________________

Section B

The following questions will help us determine your eligibility for vaccination today.

General Vaccine Screening Questions

1. Do you feel sick today?
☐ Yes ☐ No

2. Do you have any health conditions such as heart disease, diabetes, or asthma?
☐ Yes ☐ No

3. Do you have allergies to latex, medications, food, or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, or thimerosal)?
☐ Yes ☐ No

4. Have you ever had a reaction (allergic or otherwise) after receiving an immunization?
☐ Yes ☐ No

5. Do you have a seizure disorder for which you are on seizure medications, or a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?
☐ Yes ☐ No

6. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, or transplant)?
☐ Yes ☐ No

7. For women: Are you pregnant or considering becoming pregnant in the next month?
☐ Yes ☐ No

Section C

COVID-19 Vaccine Screening Questions

16. Have you ever received a dose of COVID-19 vaccine?
☐ Yes ☐ No

17. Have you ever had an allergic reaction to a component of a COVID-19 vaccine, including: Polyethylene glycol (PEG) or Polysorbate?
☐ Yes ☐ No

18. Check all that apply to you: (e.g., weakened immune system, pregnant, received monoclonal antibodies, etc.)
☐ Yes ☐ No

Section D (Consent and Release)

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of person to receive vaccine and VIS: ______________________________ Date: ___________

Insurance information and authorization

I hereby authorize the pharmacy to bill my insurance on my behalf for the immunizations and receive payment.
☐ Non-medicare ☐ Pharmacy ☐ Medical Medicare Card No.: ______________________________

Vaccine Information:

Vaccine	MFR	Date admin.	Vaccine lot no.	Exp. date	Dosage