

Medication Administration/ Immunization Consent Form

Name: _____ Phone: _____

Date of Birth: _____ Age: _____ Gender (circle one): Male / Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Screening Questions (if you answer yes, please explain below)

Please circle

- | | | |
|--|-----|----|
| 1. Are you sick today? | Yes | No |
| 2. Do you have allergies to medications, food (esp. eggs), a vaccine component, or latex? List all. | Yes | No |
| 3. Have you ever had a serious reaction after receiving a vaccination? | Yes | No |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | Yes | No |
| 5. Do you have cancer, leukemia, AIDS, or any other immune system problem? | Yes | No |
| 6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? | Yes | No |
| 7. Have you had a seizure or a brain or other nervous system problem? | Yes | No |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | Yes | No |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | Yes | No |
| 10. Have you received any vaccinations in the past 4 weeks? | Yes | No |

Consent and waiver: I consent to the staff to administer the medication(s) mentioned below. I have reviewed the **vaccine information sheet** (s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the **standing order physician (Jennifer Dillaha, MD)** and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that **I have received a copy of the pharmacy's privacy policies according to HIPPA**. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. I am aware that an immunization certified student pharmacist might be administering this medication. **I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.**

Signature of patient X: _____ Date: _____

Below is for pharmacy documentation

Medication: _____ VIS Date: _____ Lot #: _____ Exp Date: _____ Site: _____

Medication: _____ VIS Date: _____ Lot #: _____ Exp Date: _____ Site: _____

Administered by: _____ Title: _____ Date Given: _____