

**Appointment Information** 

## Vaccination Permission, Release, & Screening Consent Form for Adults

Appointment Date:	Location: Insurance									
mical Service(s) Requested:  Member ID/Policy #:  Group #:  BIN:							PCN:			
Patient Information										
Name:	Gender:		Date of Birt		Phone:	:				
Street Address:		City:	State:		Zip code:					
IF LESS than 66 lbs., list weight:	lbs.	PCP Name:	PCP Phone #:		PCP Fax		#:			
Race: ☐ Asian ☐ American Indian ☐ Pa	acific Island	er 🗆 Black or Africa	n American 🗆 C	aucasian 🗆 Other	r:					
Ethnicity: ☐ Hispanic or Latino ☐ Non-His	spanic or La	tino 🗆 Decline to st	tate/ Unknown							
Screening Questions						Y	es No	o Kno	wDon't	
Are you sick today?										
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?										
3. Have you ever had a serious reaction after receiving a vaccine?										
4. Do you have a long-term health proble clotting disorder, no spleen, complem longterm aspirin therapy?		= -		· -						
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?										
6. Do you have a parent, brother, or sister with an immune system problem?										
7. In the past 3 months, have you taken anticancer drugs; drugs for the treatm treatments?		· · · · · · · · · · · · · · · · · · ·	-	•						
8. Have you had a seizure or a brain or o	ther nervo	us system problem?	)							
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?										
10. Are you pregnant or is there a chance you could become pregnant during the next month?										
11. Have you received any vaccinations (	e.g., flu, sh	ingles, COVID-19) ii	n the past 4 wee	eks?						
<ul> <li>I authorize the Pharmacy to submit a claim to m</li> <li>I fully understand that I will ultimately be respor co-pays, deductibles or coinsurance obligations</li> <li>I certify that I am the patient and at least 18 yea otherwise competent or unable to consent for tl</li> <li>I have been provided the Vaccine Information St the risks and benefits.</li> <li>I GIVE CONSENT to the pharmacy and its staff fo</li> </ul>	nsible for any of that apply. rs of age; the nemselves. atement or Er	charges if I am not a cover legal guardian of the pat mergency Use Authorizat	ered person under the ient; or a person aution Fact Sheet for R	thorized to consent on ecipients & Caregivers	vided, the service behalf of the pat for the vaccine(s)	es are not co	vered s	services, ient is no	or for an	
I hereby certify that the above informa			best of my knov			and cond	litions	stated	l above	
Signature:			Date:							

Ordering RPh									VIS / EUA Pub Date
Vaccine Name	Lot #	Expiration Date	Manufacturer	NDC #	Dose #	Dose (mL)	Site	Route	