VACCINE CONSENT FORM

Vaccines Requested Today:
- ❑ Flu
- ❑ Pneumonia
- ❑ Flu (HD-65 or older)

Billing Method: ❑ Medicare* ❑ Insurance* ❑ None
*Please provide copy of prescription insurance or Medicare Card

***Medicare Number:** ______________________________

Other vaccines available:
- ❑Td/Tdap
- ❑ Shingrix
- ❑ RSV (recommended for 75 yr. & older)
- ❑ ________________________

NAME: ____

ADDRESS: STREET ____________ CITY ____________ STATE ____________ ZIP ____________

E-MAIL: ____ **Phone:** ____________________

D.O.B. ____________________________ **Age:** ____________ ❑ Male ❑ Female

Please answer the following questions:

		Yes	No
1	Do you have a fever or illness today or are you taking an antibiotic?		
2	Are you pregnant or breastfeeding?		
3	Have you ever had a serious reaction (i.e., Anaphylaxis) to any other vaccine in the past or do you have a food, egg, or latex allergy?		

ONLY ANSWER THE FOLLOWING IF RECEIVING VACCINE OTHER THAN FLU/PNEUMONIA:

		Yes	No
5	Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder?		
6	Do you take biologics, cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?		
7	Have you had a seizure or a brain or other nervous system problem?		
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?		
9	Have you received any vaccine in the last 4 weeks?		

***Primary Care Physician:** ____

I request the vaccine be administered to me or the person named above, for whom I am authorized to make decisions. I have read or have had information about this vaccine explained to me. I understand the benefits and risks associated with the vaccine and choose to assume the risk. As with all medical treatment, I realize that there is no guarantee that I will not experience an adverse side effect from the vaccine. Furthermore, I hereby release and discharge Dr. Stephanie Han, Dr. Kimberly Pettit and King's Pharmacies and their officers, board members and employees from any and all liability for illness, injury, loss, or damage which may result from this immunization. I authorize King's Pharmacy to receive payment for any immunizations from my primary billing provider.

____ ____________________

***Signature** (Parent or Guardian if minor) Date

**********PLEASE DO NOT WRITE BELOW THIS LINE**********

Place Stickers Here	Dose	VIS Date
	SITE	**Given By:**
	LD RD	