Immunization Consent Form

PERSONAL INFORMATION

LAST NAME FIRST NAME MI GENDER

ADDRESS CITY STATE ZIP

PHONE NUMBER BIRTH DATE (MM/DD/YYYY)

PRIMARY CARE PROVIDER PROVIDER PHONE/FAX

INSURANCE CARRIER: _____ ID: _____ GROUP: _____

WHICH VACCINE(S) WOULD YOU LIKE TO RECEIVE TODAY?

☐FLU ☐HEBATITIS A ☐HEPATITIS B ☐TDAP ☐HPV ☐PNEUMONIA ☐SHINGLES ☐MENINGITIS ☐OTHER_____

PRECAUTIONS AND CONTRAINDICATIONS (Please check yes or no for each question.)

	Yes	No
1. Are you sick today?		
2. Do you have allergies to medications, food (e.g. eggs), latex or vaccine component? If yes, please list		
3. Have you ever had a serious reaction (Including feeling dizzy or fainting) after receiving an immunization?		
4. Do you have a long-term health problem such as heart disease, lung disease, liver disease, Asthma, Kidney disease, metabolic disorder (e.g. diabetes), Anemia, or other blood disorder?		
5. Do you have Cancer, leukemia, HIV/AIDS or any other immune system problem?		
6. In the past 3 months, have you taken medications that weaken your immune system; like cortisone, prednisone, other steroids or anti-cancer drugs, or have you had radiation treatments?		
7. Have you had a seizure, brain, nerve problem, or Guillain-Barre Syndrome?		
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?		
9. **For women:** Are you pregnant or is there a chance you could become pregnant during the next month? …..		
10. Has any Physician or other healthcare professional cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital?		
11. Have you received any vaccinations in the past 4 weeks? If yes, what vaccines?		
12. For Tdap and adult TD (only) do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?		
13. Do you have any current medical conditions? If yes, please list …….		

***An immunization must not be given if there is a Yes answer to question 10 or 12, any other affirmative answers should have clinical due diligence per protocol.**

I certify that I am: (i) The patient and at least 18 years of age; (ii) The parent or legal guardian of the minor patient; or (iii) The legal guardian of the patient. Further, I hereby give my consent to the health care provider of Vaxon, LLC to administer the vaccine(S) I have requested above. I understand that it is not possible to predict all possible side effects or complications as associated with receiving the vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have read, and/or had explained to me the Vaccine Information Statements (VIS) on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Vaxon, LLC its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of vaccine(s) listed above. I authorize Vaxon, LLC to release medical or other information to my health care professionals, Medicare, Medicaid or other third party payor necessary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Vaxon, LLC with respect to the vaccine(s) listed above.

_____ Date:_____

SIGNATURE OF PATIENT OR (LEGAL GUARDIAN, IF PATIENT UNDER 18) (FOR LEGAL GUARDIANS ONLY; PRINT NAME and RELATIONSHIP)

ADMINISTRATIVE RECORD FOR INTERNAL USE ONLY

☐ Immunizer counseled patient to remain near location for 15-20 minutes

_____ _____

DATE OF VACCINATION/DATE VIS GIVEN RPh/Intern/NP/PA/LPN/RN SIGNATURE

VACCINE: _____ SITE OF INJECTION: _____
LOT NUMBER: _____ EXPIRATION DATE: _____
ROUTE OF ADMIN: _____ MANUFACTURER: _____
VIS VERSION: _____ DOSAGE: _____

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