# VACCINE CONSENT FORM

First Name:_____ Middle Initial:_____ Last Name: _____

Address:_____ City:_____ State:_____ Zip: _____

Phone: (_____)_____ Emergency Contact:_____ Phone: (____) _____

Birth date:_____/_____/_____ Age:_____ Sex: M F Primary Care Physician _____

The questions below will allow us to determine if you are eligible for a vaccine today .If any question is unclear, please ask a pharmacist for assistance.

| | ALL VACCINES | YES | NO |
|---|---|---|---|
| 1. | Do you feel sick today or have a fever or infection? | _____ | _____ |
| 2. | Have you ever fainted on felt dizzy after receiving a vaccination? | _____ | _____ |
| 3. | Have you ever had a reaction after receiving a vaccine? | _____ | _____ |
| 4. | Do you have long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. Diabetes) or anemia or another blood disorder? | _____ | _____ |
| 5. | Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs? | _____ | _____ |
| 6. | Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, B-bovine protein, gelatin, gentamycin, neomycin, phenol, yeast or thimerosal? | _____ | _____ |
| 7. | Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain Barre' syndrome or other nervous system problems? | _____ | _____ |
| 8. | For women: Are you pregnant or considering becoming pregnant next month? | _____ | _____ |
| 9. | If 5-17 years old are you taking aspirin or any aspirin containing products? | _____ | _____ |
| 10. | Have you taken any anti-virals (i.e.Tamiflu, valacyclovir) within the past 48 hours? | _____ | _____ |
| 11. | Has it been more than 10 years since your last tetanus shot? | _____ | _____ |
| 12. | If you are 65 older have you had a pneumonia shot? | _____ | _____ |

| | LIVE VACCINES | | |
|---|---|---|---|
| 1. | Are you currently on home infusion or weekly injections? | _____ | _____ |
| 2. | Have you received any vaccinations or skin tests in the past four weeks? | _____ | _____ |
| 3. | Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year? | _____ | _____ |
| 4. | Do you have a history of thymus disease (including myasthenia gravis), or thymectomy? (Yellow Fever) | _____ | _____ |
| 5. | Are you currently taking any antibiotics or antimalarial medications? ( Oral Typhoid only) | _____ | _____ |

I acknowledge that I have received, read, and understand the Vaccine Information Statement for the vaccine(s) listed below. I have had the chance to ask questions about the contents of the Vaccine Information Statement. I understand the benefits and risks of the vaccine, and I believe that benefits of receiving the influenza vaccine outweigh the risks associated with receiving the vaccine. I hereby consent to have the vaccine administered to me by the company pharmacist. I understand and agree that this company may be required by applicable law to report certain information without notice to me about my vaccination to the appropriate state and federal regulatory authorities for purposes such as reporting of adverse events or immunization registries. I further agree to hold harmless BI-LO, LLC and its subsidiaries, officers, employees, agents, representatives, contractors, successors and assignees from any claim or action arising out of or, in any way incidental to this vaccination. I am 18 years or older, under no duress, and have read and understand this informed consent for the vaccine listed below. I will communicate the information provided to me today about my vaccination to my primary care provider, if I have one.

By signing below, I certify that I am the patient or the patient's guardian/personal representative signing on behalf of the patient. I read, understand and agree to all the statements on this form.

_____ _____ _____

Print Name Signature of Patient or Legal Guardian Date

| Admin date | Vaccine | Vaccine Lot # | Exp Date | Manufacturer | Dosage | Site of Injection | VIS Date |
|---|---|---|---|---|---|---|---|
| | | | | | | IM/SQ L/R Deltoid/PLUA | |
| | | | | | | IM/SQ L/R Deltoid/PLUA | |
| | | | | | | IM/SQ L/R Deltoid/PLUA | |
| Signature of Pharmacist | | | | | | | |