

IMMUNIZATION CONSENT FORM

LAST Name: _____
First Name: _____ **Middle Initial:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone: _____ **DOB (m/d/y):** ____/____/____ **Age:** _____ **Sex (M/F):** _____

Precautions and Contraindications:	Please check YES or NO for each question.		
	YES	NO	NOT SURE
1. Are you sick today, been tested in the last 10 days for Covid due to symptoms, or been told to quarantine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have sensitivity to:			
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Eggs or Egg Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thimerosal (preservative in cleaning products/contact lens solution)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polysorbate, found in some vaccines, film coated tablets, IV steroids.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous Covid-19 Vaccines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Other Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had an allergic reaction to a vaccine? VACCINE ALLERGIES _____ (Severe allergic reaction [e.g., anaphylaxis] requiring epinephrine or EpiPen® or the hospital. It also includes an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of vaccine or injectable medication? NON-VACCINE ALLERGIES _____ This would include food, pet, venom, environmental, or oral medication allergies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received any vaccine in the last 14 days? If yes, which vaccine _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received Monoclonal Antibodies, Immune Globulin, a Transfusion of Blood, or Blood Products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you currently taking cortisone, prednisone, other steroids, anti-cancer drugs, or had X-Rays recently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a weakened immune system caused by something such as HIV/AIDS, leukemia, cancer, or do you take immunosuppressive drugs or therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you currently being treated for a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (Diabetes), anemia, or other blood disorders? Health Issue _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have a bleeding disorder or are you taking a blood thinner? If yes, which one applies: <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Blood Thinners <input type="checkbox"/> Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a history of Thrombocytopenia or any other Platelet disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever had a seizure disorder treated with medications, a brain disorder, Guillain-Barre Syndrome, or other nervous system (neurological) problems/disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have dermal fillers? (A cosmetic procedure that injects gels under the skin to reduce lines)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. WOMEN: Are you, or do you suspect, you are pregnant /breastfeeding or may become pregnant in the next 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you a parent, family member, or caregiver to a new born infant, or young children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever fainted or felt extreme dizziness after receiving an immunization/vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD THE FOLLOWING VACCINES

	YES	NO		YES	NO
Pneumococcal (Pneumonia) Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Syncytial Virus (RSV) Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Zoster (Shingles) Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Covid Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough (Tdap) Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Other Vaccine _____	<input type="checkbox"/>	<input type="checkbox"/>

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small. Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection. Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate, presumable allergic reactions such as hives, angioedema, allergic asthma, or systemic anaphylaxis occur rarely after immunization. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to any vaccine components may be at increased risk of reactions from immunizations. In the case of a severe reaction such as a high fever, behavior changes, or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes, to a few hours, after the shot.

Which Vaccine(s) are you getting TODAY?

<input type="checkbox"/> Influenza > 65 Years Old	<input type="checkbox"/> Influenza Normal	<input type="checkbox"/> Pneumococcal
<input type="checkbox"/> Whooping Cough(Tdap)	<input type="checkbox"/> Respiratory Syncytial Virus (RSV)	<input type="checkbox"/> Zoster (Shingles)
<input type="checkbox"/> Covid > 65 Years Old	<input type="checkbox"/> Covid - Pfizer	<input type="checkbox"/> Covid - Moderna

Name of Primary Care Physician (PCP): _____

City and State of Office Location: _____

IMMUNIZATION CONSENT FORM

CONSENT FOR SERVICES, MEDICAL RECORDS and HIPAA PRIVACY INFORMATION

I have read the adverse reactions associated with the vaccines. A copy of the Vaccine Information Sheet has been provided to me. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result. I give my consent for my medical record to be shared with my physician, insurance, and the NYS Immunization Information System. All vaccinations provided by this facility will be reported to NYSIIS. I am requesting that the immunization(s) be given to me or the person named below for whom I am the legal guardian. I, for myself, my heirs, executors, personal representatives and assigns, hereby release the Rock Hill Pharmacy and its employees, from any and all claims arising out of, in connection with or in any way related to my receipt of this or these immunization(s). Rock Hill Pharmacy and the aforementioned parties shall not at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The Rock Hill Pharmacy will use and disclose your personal and health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES to help you better understand our policies in regards to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices.

X _____
Signature/Legal Guardian

Date

Print Name

Immunizer's Signature

Medicare Beneficiaries ONLY

I understand that I am giving Rock Hill Pharmacy permission to ask for Medicare payments for my medical care, including supplies and equipment. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.

I understand that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. I understand that a copy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or co-insurance amounts.

Therefore, I ask that payment of authorized Medicare benefits be made to either me or on my behalf to Rock Hill Pharmacy for any services or items furnished to me by Rock Hill Pharmacy. I authorized any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits for related services. I have received a copy of the Medicare Supplier Standards.

X _____
Signature of Beneficiary

Date

Print Name

HICN

PHARMACY USE ONLY

Place Rx Label Here:

Manufacture: _____	Injection Site: R / L IM Delt / SQ	Manufacture: _____	Injection Site: R / L IM Delt / SQ
Expiration: _____	Lot: _____	Expiration: _____	Lot: _____