Vaccine Administration Record

GLENWOOD SOUTH PHARMACY+MARKET

SECTION A *(Please print clearly.)*

First name: _____ Last Name: _____ Date of birth: _____ Age: _____

GENDER: Male Female RACE: (CIRCLE ONE) CAUCASIAN AFRICAN-AMERICAN HISPANIC ASIAN OTHER

Address: _____ City: _____ State _____ Zip: _____

Email: _____ Phone: _____ Mother's Maiden Name: _____

Medicare Number: _____ SS # (last 4 digits only)_____

Doctor/primary care provider name: _____ Phone number: _____

Vaccine Requested _____

SECTION B *Answer all questions*

1. Do you feel sick today? ___Yes ___No
2. Do you have any health conditions such as: heart disease, diabetes or asthma? ___Yes ___No
   If yes, please list:
   _____
3. Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, thimerosal, neomycin, yeast) ____ Yes ____No
   If yes, please list. _____
4. Have you ever had a reaction after receiving an immunization, including fainting or feeling dizzy?
   . ____Yes ___No
5. Has any doctor ever cautioned you about receiving any vaccine outside of a medical setting?
   . ___Yes ___No
6. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?
   . ___Yes ___No
7. For women: Are you pregnant or considering becoming pregnant in the next month?
   . ___Yes ___No

SECTION C

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the pharmacist of Glenwood South Pharmacy + Market to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements 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 healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, officers 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 the vaccine(s) listed above.

I acknowledge that the applicable Provider may disclose my immunization information to the State Registry for purposes of public health reporting or to my health care providers enrolled in the State Registry for purposes of care coordination. By signing below, I hereby do consent to the applicable Provider reporting my immunization information to the State Registry to the entities and for the purposes described in this Informed Consent form. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian) proof of immunization to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian) is a student or prospective student. I further authorize the applicable Provider to (a) release my medical or other information to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Patient or Legal Guardian signature: _____Date: _____

Patient name (print): _____