RIVERVIEW PHARMACY AND SURGICAL SUPPLIES

2405 Hamburg Turnpike, Suite C, Wayne, NJ 07470
973.831.4080 (phone), 973.831.4081 (fax)

Vaccine Administration Record - Informed Consent for Vaccination

SECTION A (please print clearly)

Date: _____

First Name: _____ MI: _____ Last Name: _____

Home Address: _____ City, State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Gender (circle one): Male / Female

Email Address: _____ Telephone: _____

Name of your Primary Care Physician: _____

Physician's Office Address: _____ City, State: _____ Zip Code: _____

Check Type of Vaccine Requested: ☐ Flu Shot ☐ Pneumonia ☐ Other (Specify)_____

SECTION B

Please answer the following questions to help us determine your eligibility to be vaccinated today.
For **ALL VACCINES**: Complete questions 1 through 8.
For any **LIVE VACCINES** (including Flu Nasal Spray and Zostavax): Complete questions 1 through 12.

FOR ALL VACCINES	YES	NO	DON'T KNOW
1. Do you feel sick today?			
2. Do you have allergies to any medications, food or any vaccine? (Ex. Eggs, Bovine Protein, Gelatin, Gentamicin)			
3. Have you received any vaccinations in the past 4 weeks? If yes, please list these:			
4. Have you ever had a serious reaction after receiving a vaccination?			
5. Do you have a neurological disorder such as seizures or other types of brain disorders, Guillan-Barre Syndrome?			
6. Are you 65 years of age or older OR do you smoke OR have chronic conditions such as Asthma or Diabetes?			
7. If you answered YES to question #6, have you ever had a "pneumonia" (Pneumococcal) vaccination?			
8. For women: Are you pregnant or considering becoming pregnant in the next 3 months?			
FOR LIVE VACCINES			
9. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
10. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have had radiation treatments?			
11. Are you currently on any weekly injection medications such as Humira, Remicade, Enbrel, Kineret?			
12. Have you received a transfusion of blood or blood products, or a medicine called immune (gamma) globulin?			

I understand that it is highly advisable to WAIT near the vaccination location for 15-20 minutes after receiving the vaccine.

I have had a chance to ask questions that were answered to my satisfaction about the vaccine, and how the vaccine is to be given. I understand the benefits and risk of the vaccine and authorize the healthcare provider to administer the vaccine. I hereby irrevocably agree to release Savings Pharmacy and Surgical Supplies, its employees, agents and representatives from any and all liability associated with the provision of the vaccine, including all losses, claims, damages, liabilities, and costs (including attorney's fees) incurred by me at any time following the receipt of any vaccine.

- ☐ **I authorize the pharmacist to send copies of my vaccine records to my Primary Care Physician**
- ☐ **I prohibit the pharmacist from sending copies of my vaccine records to my Primary Care Physician**

Patient Name (Print): _____ **Patient Signature:** _____

Pharmacist Name (Print): _____ **Pharmacist Signature:** _____

Vaccine:
Manufacturer:
Lot #:
Exp Date:
Site & Dose:

Riverview Pharmacy
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