Vaccine Consent & Billing Form

PERSONAL INFORMATION					
FIRST NAME	MIDDLE INITIAL	LAST NAME			
ADDRESS		CITY	STATE	ZIP	
	☐ Female ☐ Male				
PHONE	GENDER	DATE OF BIRTH	AGE	ALLERGIES	

SCREENING QUESTIONS

Are you sick today?	☐ Yes ☐ No
Do you have allergies to medications, food, a vaccine component, or latex?	☐ Yes ☐ No
Have you ever had a serious reaction after receiving a vaccination?	☐ Yes ☐ No
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐ Yes ☐ No
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
Do you have history of pericarditis, myocarditis, or Multisystem Inflammatory Syndrome in Adults (MIS-A)?	☐ Yes ☐ No
In the past 3 months, have you taken medications that weaken your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments?	☐ Yes ☐ No
Have you had a seizure or a brain or other nervous system problem?	☐ Yes ☐ No
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ Yes ☐ No
Have you received any vaccinations in the past 4 weeks?	☐ Yes ☐ No
For women: Are you breastfeeding, pregnant or is there a chance you could become pregnant during the next month?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

Please check the vaccine that is being administered:

☐ Influenza	☐ Hepatitis A	☐ Td	☐ Covid	☐ Zoster (Shingles)
☐ Pneumococcal	☐ Hepatitis B	☐ Tdap	☐ RSV	☐ Other: _____
☐ HPV	☐ Meningococcal	☐ MMR	☐ Typhoid	

I have read or have had explained to me the information in the Vaccine Information Statement about the vaccine that I am requesting. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges. For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGNITURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR GUARDIAN) DATE

FOR CLINIC/OFFICE USE ONLY

IMMUNIZER	DATE OF IMMUNIZATION	VIS DATE	ARM (CIRCLE) L R
VACCINE	MANUFACTURER	LOT NUMBER	DIAGNOSIS CODE Z23
INSURANCE	ID NUMBER		GROUP NUMBER