



Medicare # _____

Cash Yes No

Patient Request & Consent for Vaccination

Patient Information		
Name:		
Address:		
Date of Birth:	Age:	Tel:
Primary Care Provider (MD, NP, PA):		
Drug Allergies:		
Which vaccine(s) are you requesting today?		
<input type="checkbox"/> Flu	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shingles
<input type="checkbox"/> MMR	<input type="checkbox"/> Tdap	<input type="checkbox"/> Other:

Please answer the following questions:	Yes	No	Not Sure
Are you sick today?			
Are you allergic to eggs, latex, or any vaccine component, such as gelatin or neomycin?			
Have you ever had a serious reaction after receiving a vaccination?			
Any history of Guillain-Barre' Syndrome, seizure disorder, or other neurological condition?			
For Women Only: Are you pregnant or is there a chance you could become pregnant during the next month?			

Please identify any vaccine(s) you have already received:
<input type="checkbox"/> Shingles <input type="checkbox"/> Tetanus/Pertussis
<input type="checkbox"/> Pneumonia <input type="checkbox"/> Other(s):

Please check any chronic or long-term health conditions you may have:		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Smoking	<input type="checkbox"/> Other:	

For Patients Receiving Live Vaccines Only: (e.g. shingles, chickenpox, and MMR)	Yes	No	Not Sure
Have you received any vaccines in the past 4 weeks?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Have you taken any steroids, anti-cancer drugs, antivirals, immunosuppressive medications, or have you had radiation treatments in the last 3 months?			
In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?			

I hereby give my consent to Raley's, Bel Air, and Nob Hill pharmacies to administer the vaccines(s) I have requested on this form. I understand the benefits and risks of receiving this vaccine(s). I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration. I understand that my immunization information will be shared with my primary care physician and local immunization registry, but that I have rights pertaining to the use of this data, including the right to prevent sharing with other registry users by completing and submitting a "Decline to Share" form to my local registry Help Desk. For more information, California patients should visit the CAIR website (<http://cairweb.org/cair-forms/>), and Nevada patients should ask their pharmacy team members for a participation form.

Patient/Guardian Consent: _____

Date: _____

Patient (or Legal Guardian if under 18)



Healthcare Provider Section

This patient received the following vaccine(s) in our pharmacy today as per ACIP recommendations and in conjunction with our vaccination protocol. This data will be entered in to the vaccination state registry within 24 hours.

Patient Name: _____ **DOB:** _____

Store #: _____ **Phone#:** _____ **Fax#:** _____

Place transaction label here.

Place transaction label here.

Vaccine(s) given today:	Route:	Site:	Lot & Expiration date	VIS Edition Date
Influenza (IIV4, RIV4, LAIV4, cclIV3,)	IM	RD LD		Inactivated: 8/17/15 Live, Intranasal: 8/7/15
Pneumonia (PPSV23, PCV13)	IM	RD LD		PCV13: 11/5/15 PPSV23: 4/24/15
Adacel or Boostrix (Tdap, Td)	IM	RD LD		Tdap: 2/24/15 Td: 4/11/17
Meningococcal (MenACWY, MenB)	IM	RD LD		MenACWY: 3/31/16 MenB: 8/9/16
Human Papillomavirus (HPV)	IM	RD LD		HPV: 12/2/16
Shingrix (RZV)	IM	RD LD		RZV: 2/12/18
Zostavax (HZV)	SC	RT LT		HZV: 2/12/18
Measles, mumps, Rubella (MMR-II)	SC	RT LT		MMR II: 2/12/18
Varicella (VAR)	SC	RT LT		VAR: 2/12/18
				Hep A: 7/20/16 Hep B: 7/20/16

Immunizing Pharmacist's Signature: _____ **Date:** _____