



# VACCINE CONSENT FORM

<input type="checkbox"/> RPh/Tech Name: _____	(Internal/Off Site Clinic Information)
<input type="checkbox"/> Phone/Fax Date: _____/_____/_____	
<input type="checkbox"/> Phone/Fax Time: _____:_____/_____ AM/PM	
<input type="checkbox"/> Registry Date: _____/_____/_____	

First Name: _____		MI: _____		Last Name: _____	
Home Phone: (____) _____-____		Date of Birth: ____/____/____		Age: _____	Gender: M / F
Home Address: _____		City: _____		State: _____	Zip Code: _____
Primary Healthcare Provider: _____		Physician Address: _____		Physician Phone: (____) _____-____	
Insurance Carrier Name: _____		Cardholder ID: _____		Group Number: _____	

**I WANT TO BE PROTECTED FROM THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):**  FLU  HEPATITIS A  HEPATITIS B  HPV  
 MEASLES/MUMPS/RUBELLA (MMR)\*  MENINGITIS  PNEUMONIA  SHINGLES  TDAP  VARICELLA\*  OTHER (PLEASE SPECIFY): \_\_\_\_\_

Please answer the following questions so we can assess the safety and the appropriateness of vaccination:		Yes	No
<b>ALL VACCINES</b>	1. Do you have a long-term health problem? If yes, please list: _____		
	2. Do you have a fever or illness today?		
	3. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list what you are allergic to: _____		
	4. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	5. Have you had the vaccine (s) you are receiving today before?		
	6. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	7. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date: _____		
	8. <b>For Women:</b> Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
<b>*LIVE VACCINES</b>	9. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	10. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira, Enbrel) or had radiation treatments? If yes, list medication, dose, and date last taken: _____		
	11. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, list medication, dose, and date last taken: _____		

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or legal guardian of the minor Patient; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the health care provider of Harris Teeter Grocery Stores 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 health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Harris Teeter Grocery Stores its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors 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 authorize Harris Teeter Grocery Stores to release any medical or other information to my health care professionals, Medicare, Medicaid or other third party payor necessary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Harris Teeter Grocery Stores with respect to the vaccine(s) listed above.

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

**\* FOR INTERNAL USE ONLY \***  Immunizer counseled patient to remain near location for 15-20 mins – **MUST CHECK BOX**

Vaccine Name: _____	Vaccine Name: _____	Vaccine Name: _____
Manufacturer: _____	Manufacturer: _____	Manufacturer: _____
Dose: _____ Series #: _____ of _____	Dose: _____ Series #: _____ of _____	Dose: _____ Series #: _____ of _____
Vaccine Lot #: _____	Vaccine Lot #: _____	Vaccine Lot #: _____
Vaccine Exp. Date: _____	Vaccine Exp. Date: _____	Vaccine Exp. Date: _____
Diluent Lot #/Exp. Date: _____	Diluent Lot #/Exp. Date: _____	Diluent Lot #/Exp. Date: _____
Injection Site: <b>LEFT/RIGHT; ARM/THIGH</b>	Injection Site: <b>LEFT/RIGHT; ARM/THIGH</b>	Injection Site: <b>LEFT/RIGHT; ARM/THIGH</b>
Route: <b>IM or SubQ</b>	Route: <b>IM or SubQ</b>	Route: <b>IM or SubQ</b>
VIS Given: ____/____/____ Version Date: ____/____/____	VIS Given: ____/____/____ Version Date: ____/____/____	VIS Given: ____/____/____ Version Date: ____/____/____
Supervising RPh/Lic#: _____ (if required)		
Immunizer: _____	RPh/Intern/NP/PA/LPN/RN	Date Administered: ____/____/____ Time: _____ AM/PM

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