



CLINIC			
ADMIN USE ONLY			
BILLED		CASH	GRITS

## IMMUNIZATION CONSENT FORM

\*\*\*All sections must be filled completely\*\*\*

PATIENT INFORMATION					
LAST NAME			FIRST NAME	M.I	
DATE OF BIRTH			GENDER	____ MALE ____ FEMALE	
ADDRESS				APT #	
CITY			STATE	ZIP	
HOME PHONE			CELL PHONE		
INSURANCE INFORMATION					
DO YOU HAVE ANY PRESCRIPTION INSURANCE?		<input type="checkbox"/> PRIVATE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> NO			
INSURANCE BIN #			PCN #		
GROUP #			MEDICARE / PRIVATE INSURANCE ID #		
*OPTIONAL*		PRIMARY CARE PHYSICIAN INFORMATION		*OPTIONAL*	
NAME					
ADDRESS					
CITY			STATE	ZIP	
PHONE			FAX		
VACCINATION					
VACCINE REQUESTED	<input type="checkbox"/> COVID <input type="checkbox"/> FLU <input type="checkbox"/> PNEUMONIA <input type="checkbox"/> SHINGLES <input type="checkbox"/> MENINGITIS <input type="checkbox"/> OTHER				
CASE HISTORY AND LISTED CONTRAINDICATIONS					
PLEASE ANSWER THE FOLLOWING QUESTIONS					
ALL VACCINES					
QUESTION	YES	NO	DON'T KNOW		
1. Have you had a physical examination within the past year?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
2. Are you sick today?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
3. Do you have allergies to medications, eggs or other food, a vaccine component, latex or gelatin, thimerosal, or neomycin? If Yes, list allergies below	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
4. Have you ever had a serious reaction after receiving a vaccination?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
5. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
7. Have you had a seizure, brain disorder, Guillain-Barre Syndrome or other nerve problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
LIVE VACCINES (ZOSTAVAX ONLY)					
1. In the past 3 months, have you taken any medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
2. During the past year, have you received a transfusion of blood or blood products, or been given a immune (gamma) globulin or an antiviral drug?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
3. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
4. Have you received any vaccinations in the past 4 weeks?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
If Yes, What Vaccines?					

\*\*\* FORM CONTINUES ON PAGE 2 \*\*\*

### PATIENT CONSENT

I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient ('Ward'). I have received a copy of the applicable Vaccine Information Statement(s) and I have read the adverse reactions associated with the administration of vaccine(s). Furthermore, I consent to the administration of the vaccine(s) requested above to me or my Ward and acknowledge that, as a condition to administration of the vaccine(s), myself or my Ward must remain under observation of the administering pharmacist for a period of not less than 15 minutes. I understand that a copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have also had an opportunity to ask questions about the immunization(s). I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named above for whom I am the Ward. My medical record, may be shared with my primary care provider or other healthcare provider and the medical record of my Ward may be shared with his/her primary care provider or other healthcare provider. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Physicians Pharmacy & Medical Supply, Inc and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Physicians Pharmacy & Medical Supply, Inc nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine(s) described above. I authorize Physicians Pharmacy & Medical Supply, Inc to (a) notify me or my Ward's primary care provider of the vaccine administered and to provide same with copies of all vaccination records; (b) to enter my or my Ward's vaccine information on the Georgia Registry of Immunization Transactions; and (c) make any other disclosures required by law. Physicians Pharmacy & Medical Supply, Inc will use and disclose my personal and health information or the personal and health information of my Ward, to receive payment of the care provided, and for other health care operations. Healthcare operations include those activities performed to improve the quality of care. I acknowledge that I have received a copy of the Notice of Privacy Practices.

For Patients receiving Live Vaccines only: I further certify that I have read the list of contraindications to the vaccine(s) set forth above and neither me or my Ward have a contraindication to the vaccine[s] to be administered.

**PATIENT / LEGAL GUARDIAN SIGNATURE** \_\_\_\_\_

**PRINT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

### !!! PHARMACY USE ONLY !!!

#### ADMINISTRATIVE RECORD

<b>1</b>	VACCINE		EXP DATE		VIS VERSION/DATE	
	DATE ADMINISTERED		MANUFACTURER		LOT #	
	DOSAGE		ROUTE OF ADMIN		DATE M.D NOTIFIED	
<b>2</b>	VACCINE		EXP DATE		VIS VERSION/DATE	
	DATE ADMINISTERED		MANUFACTURER		LOT #	
	DOSAGE		ROUTE OF ADMIN		DATE M.D NOTIFIED	
<b>3</b>	VACCINE		EXP DATE		VIS VERSION/DATE	
	DATE ADMINISTERED		MANUFACTURER		LOT #	
	DOSAGE		ROUTE OF ADMIN		DATE M.D NOTIFIED	

#### ADMINISTERING PHARMACIST INFORMATION

<b>NAME &amp; TITLE</b>		<b>LICENSE #</b>	
<b>PHARMACY INFORMATION</b>	Physicians Pharmacy & Medical Supply, Inc 3875 Austell Rd Ste. 302 Austell, GA 30106 (770) 944-9101		

#### ADVERSE EVENTS/ COMPLICATIONS & NOTES


**REPORT ALL ADVERSE REACTIONS TO THE FEDERAL VACCINE ADVERSE EVENT REPORTING SYSTEM**