Vaccine Consent Form

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: ____/____/_____

Address:_____ City: _____ State: _____ Zip:_____

Phone: (___) _____ Primary Care Physician: _____ Sex: M F Medicare #:_____

Type of vaccine to be administered: ☐ Influenza ☐ Pneumococcal ☐ Other: _____

Please answer the following questions to determine if you are eligible for a vaccine. If you have any questions please ask a pharmacist for assistance.

	All Vaccines	Yes	No
1	Do you feel sick today?		
2	Have you ever had a bad reaction to a vaccine including feeling dizzy or fainting?		
3	Do you have chronic health conditions such as heart disease, lung disease, asthma, diabetes, neurologic disorders, liver disease, other: _____		
4	Do you have a weakened immune system due to HIV/AIDS or another disease that affects the immune system or do you take high dose steroids or are undergoing cancer treatment?		
5	Do you have allergies to latex, medications, food or vaccines? (eggs, gelatin, neomycin, polymixin or thimerosal)		
6	Have you ever had a seizure disorder, brain disorder (including guillan-barre) or any other nervous system disorders?		
7	Have you ever received a pneumonia vaccine?		
8	Have you ever received a tetanus and whooping cough booster?		
9	**For women**: are you pregnant or considering becoming pregnant in the next month?		
10	**If you are 5 – 17 years old**: are you taking aspirin or any aspirin containing products?		
	Live Vaccines ONLY		
11	Are you currently on home infusions or weekly injections?		
12	Have you received any vaccines or skin tests in the past four weeks?		
13	Have you received a blood transfusion, blood products, or immune globulin in the past year?		
14	Do you have a history of thymus disease or thymectomy? (yellow fever only)		
15	Are you currently taking any antibiotics or antimalarial medications? (Oral typhoid only)		

I acknowledge that I have received, read and understand the Vaccine information Statement for the vaccines(s) below. I have had the chance to ask questions about the contents of the Vaccine Information Statement. I understand the benefits and risks of the vaccine, and I believe that benefits of receiving the vaccine outweigh the risks associated with receiving the vaccine. I hereby consent to have the vaccine administered to me by the company pharmacist. I understand and agree that this company may be required by applicable law to report certain information without notice to me about my vaccinations to the appropriate state and federal regulatory authorities for purposed such as reporting of adverse events or immunization registries. I further agree to hold harmless BI-LO, LLC and its subsidiaries, officers, employees, agents, representatives, contractors, successors and assignees from any claim or action arising out of or, in any way incidental to this vaccination. I am 18 years or older, under no duress, and have read and understand this informed consent for the vaccine listed below. I will communicate the information provided to me today about my vaccination to my primary care provider, if I have one.

_____ _____ _____

Print Name | Signature of Patient or Legal Guardian | Date

Admin Date	Vaccine	Lot #	Exp Date	Manufacturer	Dosage	Site of Injection	VIS Date	Date MD Notified
						IM/SQ L/R Deltoid		
						IM/SQ L/R Deltoid		
						IM/SQ L/R Deltoid		
Signature of administering Pharmacist								