Stuarts Draft Family Pharmacy

2929 Stuarts Draft Highway • Stuarts Draft, VA 24477 • Phone: 540-337-3776

Full Name: _____

Date of Birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Medical Conditions: _____

_____

Allergies: _____

_____

Primary Care Physician (PCP): _____

PCP Contact Information: _____

_____

CONSENT FOR ADMINISTRATION OF VACCINE

_____ Hepatitis A

_____ Hepatitis B

_____ Influenza - Intranasal

_____ Pneumococcal

_____ Tetanus, Diphtheria

_____ Measles, Mumps, Rubella

_____ Meningococcal

____ Herpes Zoster

____ Influenza

_____ Varicella

____ Human Papillomavirus

_____ Rabies

PLEASE ANSWER THE FOLLOWING QUESTIONS:

	Yes	No	DON'T Know
1. Are you sick today? (For example: a cold, fever or acute illness)	❑	❑	❑
2. Do you have allergies or reactions to medications, foods or any vaccine? (For example: eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please List _____	❑	❑	❑
3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	❑	❑	❑
4. 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?	❑	❑	❑
5. Do you have cancer, leukemia, AIDS or any other immune system problem?	❑	❑	❑
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments?	❑	❑	❑
7. Have you had a seizure, brain, or other nervous system problem?	❑	❑	❑
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	❑	❑	❑
9. For women: Are your pregnant or nursing? Could you become pregnant during the next month?	❑	❑	❑
10. Have you received any vaccinations in the past 4 weeks?	❑	❑	❑
11. Do you have any planned medical procedures in the next 4 weeks?	❑	❑	❑

The health information I have provided is accurate (True). I have read, or have had read to me, the information regarding the vaccine/vaccines marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine/vaccines. I consent to, or give consent for, the administration of the vaccine/vaccines marked above to:

_____ Name (print)

_____ Signature

_____ Date

VACCINE ADMINISTRATION INFORMATION:

_____ Date _____ Product _____ Manufacturer _____ Vol (ML)

_____ Route _____ Site _____ Lot # _____ Exp Date

_____ Vis Version Date _____ Date Vis Given to PT _____ Administering Immunizer Name & Title

NOTES