NORTHWEST HILLS AT • DAVENPORT

Immunization Consent Form

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER (M/F)

ADDRESS | CITY | STATE | ZIP

10-DIGIT PHONE NUMBER | MEDICARE ID NUMBER | BIRTH DATE (MM/DD/YYYY)

PRIMARY HEALTHCARE PRESCRIBER | PRESCRIBER ADDRESS | PRESCRIBER PHONE/FAX | VACCINE REQUESTED

PRECAUTIONS AND CONTRAINDICATIONS

(Please check yes or no for each question)

1. Are you sick today? ☐ Yes ☐ No
2. Do you have allergies to medications, food or vaccines? ☐ Yes ☐ No
   Allergies _____
3. Have you ever had a serious reaction after receiving a vaccination? ☐ Yes ☐ No
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? ☐ Yes ☐ No
5. Do you have cancer, leukemia, AIDS or any other immune system problem? ☐ Yes ☐ No
6. Do you take cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments? ☐ Yes ☐ No
7. Have you had a seizure, brain or nerve problem? ☐ Yes ☐ No
8. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? ☐ Yes ☐ No
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ☐ Yes ☐ No
10. Have you received any vaccinations in the past 4 weeks? ☐ Yes ☐ No
    If yes, what vaccines? _____
11. Are you allergic to eggs? ☐ Yes ☐ No
12. Are you allergic to latex? ☐ Yes ☐ No

ADVERSE REACTIONS

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of any vaccine causing serious harm, or death, is extremely small.

Local symptoms may include: slight tenderness, redness, itching or swelling at the site of injection.

Systemic symptoms may include: fever, malaise and muscle pain. Other systemic symptoms may occur infrequently. These reactions usually begin 6 to 12 hours after immunization and can persist for a few days. Immediate presumable allergic reactions such as hives, angioedema, allergic asthma or systemic anaphylaxis occur rarely after immunization. These reactions may result from hypersensitive reactions in people with severe egg allergy, and such people should not be given certain vaccines that contain eggs. People with documented immunoglobulin E (IgE)-mediated hypersensitivities to eggs or any other vaccine components, including thimerosal, may also be at increased risk of reactions from immunizations.

In the case of a severe reaction such as a high fever, behavior changes or flu-like symptoms that occur after vaccination, see a doctor right away. Signs of an allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness within a few minutes to a few hours after the shot.

ADMINISTRATIVE RECORD

FOR PHARMACY USE ONLY

DATE ADMIN: _____	DATE ADMIN: _____	DATE ADMIN: _____
EXPIRATION DATE: _____	EXPIRATION DATE: _____	EXPIRATION DATE: _____
VACCINE: _____	VACCINE: _____	VACCINE: _____
SITE OF INJECTION: L R	SITE OF INJECTION: _____	SITE OF INJECTION: _____
VIS VERSION: _____	VIS VERSION: _____	VIS VERSION: _____
DOSAGE: 0.5 ML	DOSAGE: _____	DOSAGE: _____
MANUFACTURER: _____	MANUFACTURER: _____	MANUFACTURER: _____
ROUTE OF ADMIN: IM	ROUTE OF ADMIN: _____	ROUTE OF ADMIN: _____
LOT NUMBER: _____	LOT NUMBER: _____	LOT NUMBER: _____

FOR PHARMACY USE ONLY

☐ SCANNED ☐ FAXED TO DOCTOR

" I have read the adverse reactions associated with the administration of vaccines. 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 these immunizations. 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 below for whom I am the legal guardian ('Ward'). My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and designees, hereby release Northwest Hills Pharmacy, 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 Northwest Hills Pharmacy nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or 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 vaccines described above. Northwest Hills Pharmacy will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other heath care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward's personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices."

SIGNATURE/LEGAL GUARDIAN

PRINT NAME

Once completed, Click here to email your form to pharmacy2@northwesthills.net

DATE OF VACCINATION/DATE VIS GIVE

PHARMACIST/PRESCRIBER SIGNATURE

PHARMACY NAME/ADDRESS

PLEASE PROVIDE A COPY OF THIS FORM TO YOUR PHYSICIAN AND/OR HEALTHCARE PROVIDER FOR YOUR PERMANENT MEDICAL RECORDS.