Soldotna Professional Pharmacy Immunization Program
Informed Consent Form and Patient Record

Consent for Administration of Vaccine

- ☐ Influenza (High Dose)
- ☐ Influenza (Quadrivalent)
- ☐ Prevnar (PCV13)
- ☐ Pneumovax (PCV23)
- ☐ Varicella (Chickenpox)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis A,Hepatitis B Combo vaccine (TwinRix)
- ☐ Tetanus-diphtheria toxoids (Td, adult)
- ☐ Gardasil (patient must wait here for 15min post-immunization)
- ☐ Tetanus/diphtheria/acellular pertussis (Tdap)
- ☐ Vivotif (Oral Typhoid)
- ☐ Typhim (Injectable Typhoid)
- ☐ Measles Mumps Rubella (MMR II)
- ☐ Herpes Zoster (Shingrix)
- ☐ Meningococcal
- ☐ COVID-19 (mRNA)
- ☐ COVID-19 (viral vector)

Receipt of Vaccination Information Statement (VIS sheet)

I verify that I have received an updated copy of the most current Vaccination Information Statement regarding the vaccine/vaccines marked above. I have reviewed the information and all of my questions have been 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

Latex allergy

_____ ____/_____/_____

Name (print) Date of Birth ☐ Yes ☐ No

_____ _____-_____-_____

Signature Medicare ID Number

FOR VACCINE ADMINISTRATOR

Date of vaccination: _____ Dose of vaccination: _____

Site of vaccination: _____

Vaccine Manufacturer:_____ Lot Number: _____

Expiration Date: _____ Date of VIS: _____

Printed name of vaccine administer: _____

Signature of vaccine administrator of vaccine: _____

Please continue to other side to answer screening questions

Screening Questionnaire for Adult Immunizations

Please place a √ in the correct box to help determine if the vaccine(s) may be given.	Yes	No	Don't Know
1. Have you ever had a severe reaction to any vaccine?	□ Yes	□ No	□ Don't Know
2. Are you allergic to eggs, thimerosal, streptomycin, gelatin, or neomycin?	□ Yes	□ No	□ Don't Know
3. Do you or another member of your household have cancer, leukemia, HIV/AIDS, or other immune system problem?	□ Yes	□ No	□ Don't Know
4. Have you had a blood transfusion or received blood products such as Immune (gamma) Globulin in the last year? Do you have a bleeding disorder?	□ Yes	□ No	□ Don't Know
5. Do you have Guillan-Barre Syndrome, a condition that causes paralysis? Have you had history of encephalopathy?	□ Yes	□ No	□ Don't Know
6. Are you sick today? Do you have fever, diarrhea, or vomiting today?	□ Yes	□ No	□ Don't Know
7. Are you taking theophylline, warfarin, anticoagulant therapy, anti-cancer drugs, high dose steroids (prednisone), or inhaled corticosteriods or have you had an X-ray treatment?	□ Yes	□ No	□ Don't Know
8. Do you smoke?	□ Yes	□ No	□ Don't Know
9. For women: Are you pregnant or planning to become pregnant within the next month?	□ Yes	□ No	□ Don't Know
10. Have you received any vaccinations in the past four weeks?	□ Yes	□ No	□ Don't Know
11. Did you bring your immunization record card with you?	□ Yes	□ No	□ Don't Know
12. May we inform your healthcare provider?	□ Yes	□ No	□ Don't Know