IMMUNIZATION CONSENT FORM

PATIENT INFORMATION

RAY'S GENERAL STORE AND PHARMACY EST. 1973

PATIENT'S FIRST NAME	MI	PATIENT'S LAST NAME	GENDER	BIRTHDATE (MM/DD/YYYY)	AGE

ADDRESS	CITY	STATE	ZIP

PHONE NUMBER	PRIMARY CARE PROVIDER	PROVIDER PHONE/FAX

INSURANCE INFORMATION

RX BIN	RX PCN	RX ID	RX GROUP	MEDICARE NUMBER

VACCINE REQUESTED

☐ Flu Vaccine ☐ Shingles Vaccine ☐ Pneumonia ☐ RSV ☐ Covid-19 ☐ Other_____

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES FOR ADULTS	YES	NO	DON'T KNOW
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex? Please list:			
3. Have you ever had a serious reaction after receiving a vaccine?			
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. Do you have a parent, brother, or sister with an immune system problem?			
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
8. Have you had a seizure or a brain or other nervous system problem?			
9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
10. Are you pregnant?			
11. Have you received any vaccinations in the past 4 weeks?			
12. Have you ever felt dizzy or faint before, during, or after a shot?			
13. Are you anxious about getting a shot today?			

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.

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 assigns, hereby release Ray's 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 Ray's 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. Ray's 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 health 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	DATE

For Ray's Pharmacy Use Only:

Vaccine Administration Record

Vaccine	Vaccine Information			Date Given (MM/DD/YY)	Route (IM, SQ)	Site Given (RA,LA)	Vaccine Information Statement	
	Lot #	Exp Date	Dosage				Date on VIS	Date Given

68 North Beach Rd Eastsound, WA 98245

Printed Name of Pharmacist/Pharmacy Technician Administering Vaccine | Title | Physical Address | City, State, Zip

Pharmacist/Pharmacy Technician Signature | Overseeing Pharmacist

Drug Protocol under Dr. Camille Fleming