SPARTAN PHARMACY

VACCINE CONSENT FORM

Name _____

Date of Birth _____ (Must be 4 or older) Sex: ❑ Male ❑ Female

Address _____

City/State/Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____

Insurance Name _____

Insurance ID Number _____

Insurance Group Number _____

PCP Name _____ PCP Phone (_____)_____

PATIENT CONSENT

1. I have had a chance to ask questions and they were answered to my satisfaction. I understand the risks and benefits and ask that the injection or vaccine be given to me or to the person for whom I am authorized to make this request.
2. I have received a copy of the Vaccine Information Statement for the vaccine I will receive today:
   - ❑ Influenza
   - ❑ Twinrix (Hep A/Hep B combo) Doses at 0,1 and 6 months
   - ❑ Vaqta (Hep A) Doses at 0 and 6-18 mos
   - ❑ Energix-B 20mcg/ml -Doses at 0, 1 and 6 months
   - ❑ Gardasil 9 – repeat doses depending on age
   - ❑ MMR II – one dose
   - ❑ Menveo (meningococcal ACWY) –one dose
   - ❑ Bexsero (meningococcal B) – doses at 0 and 2 months
   - ❑ Prevnar 13 (pneumococcal) -1 dose
   - ❑ Pneumovax 23 (pneumococcal) – 1 dose
   - ❑ Shingrix (Shingles) – doses at 0 and 2-6 months
   - ❑ Td (tetanus) – 1 dose
   - ❑ Boostrix (Tdap) – 1 dose
   - ❑ Varivax (varicella) – doses at 0 and 1 month
3. FINANCIAL RESPONSIBILITY – By my signature below, I acknowledge that I have received the vaccine indicated above and authorize Spartan Pharmacy to bill and collect from my insurance for the vaccine and administration fees. If my insurance denies payment for the entire or partial amount, I agree to be personally and fully responsible for payment.

Signature _____ Date _____

Signature of parent/guardian _____ Date _____

Pharmacy use only: PA SIIS DOCU TC INS

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PATIENT SCREENING QUESTIONS

1. Are you sick today? ❑ Y ❑ N
2. Do you have allergies to medications, eggs, latex or vaccines? ❑ Y ❑ N
3. Have you ever had a serious reaction after receiving a vaccine? ❑ Y ❑ N
4. Have you received a vaccine in the last 4 weeks? ❑ Y ❑ N
5. Are you pregnant or chance you can become pregnant in the next month? ❑ Y ❑ N
6. Do you have any problems with your immune system or take medications which affect your immune system? ❑ Y ❑ N
7. Do you have a long-term health problem (heart disease, lung disease, asthma, kidney disease, anemia or other blood disorder? ❑ Y ❑ N
8. Do you or anyone living in your household have cancer, leukemia, HIV/AIDS or another immune system problem? ❑ Y ❑ N
9. Have you travelled outside of the country in the last 4 weeks? ❑ Y ❑ N

Please elaborate on any questions you answered YES: _____

_____

_____

Questions Answered by _____ Date _____

Responses Reviewed by _____ Date _____

FOR PHARMACY USE ONLY

VACCINE	DATE	SITE/ROUTE	MANUF./LOT NO	VIS DATE	DATE VIS GIVEN
COVID-19 (1st dose)				08/27/21	
COVID-19 (2nd dose)				08/27/21	
INFLUENZA				08/06/21	
TWINRIX (HepA/B)				07/20/16	
VAQTA (Hep A)				07/28/20	
ENERGIX (Hep B)				08/15/19	
MMR II				08/06/21	
PREVNAR 13 (PCV 13)				08/06/21	
PNEUMOVAX 23				10/30/19	
SHINGRIX (1st dose)				10/30/19	
SHINGRIX (2nd dose)				10/30/19	
TD				08/06/21	
BOOSTRIX (Tdap)				08/06/21	
OTHER:					

Vaccine Adminstered By _____ Title _____