VACCINE CONSENT FORM

1. Complete this interactive form online (click to type answers)
2. Print it out and sign.
3. Call us to make an appointment, and bring the printed form when you come in.

3526 Brownsville Road
Phone: 412.884.4400
M-F: 9 am - 7 pm
Sat: 9 am - 4 pm
Sun: 10 am - 2 pm

3520 Saw Mill Run Blvd
Phone: 412.440.5888
Everyday: 8 am - 8 pm

3400 South Park Road
Phone: 412.831.1333
M-F: 9 am - 7 pm
Sat: 9 am - 4 pm
Sun: 10 am - 2 p

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 (one dose)
   - ❑ 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 ______________

SPARTAN
PHARMACY

VACCINE CONSENT FORM

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: ____________________

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Questions Answered by ____________________ Date ____________________

Responses Reviewed by ____________________ Date ____________________

FOR PHARMACY USE ONLY

VACCINE	DATE	SITE/ROUTE	MANUF./LOT NO	VIS DATE	DATE VIS GIVEN
INFLUENZA				8/15/19	
TWINRIX (HepA/B)				07/20/16	
VAQTA (Hep A)				07/20/16	
ENERGIX (Hep B)				08/15/19	
MMR II				08/15/19	
PREVNAR 13 (PCV 13)				10/30/19	
PNEUMOVAX 23				10/30/19	
SHINGRIX				10/30/19	
TD				04/11/17	
BOOSTRIX (Tdap)				04/01/20	
OTHER:					

Vaccine Adminstered By ____________________ Title ____________________