HARRIS TEETER Pharmacy

VACCINE CONSENT FORM

☐ RPh/Tech Name:	(Internal/Off Site Clinic Information)
☐ Phone/Fax Date: ____/____/____	
☐ Phone/Fax Time: ____:____ AM/PM	
☐ Registry Date: ____/____/____	

First Name:	MI:	Last Name:			
Home Phone: ( ) -	Date of Birth: / /	Age:	Gender: M / F	Current Smoker? *(optional)* Yes / No	
Home Address:	City:			State:	Zip Code:
Primary Healthcare Provider:	Physician Address:			Physician Phone: ( ) -	
Insurance Carrier Name:	Cardholder ID:			Group Number:	

I WANT TO BE PROTECTED FROM THE FOLLOWING (*PLEASE CHECK ALL THAT APPLY*): ☐ FLU ☐ HEPATITIS A ☐ HEPATITIS B ☐ HPV ☐ *MEASLES/MUMPS/RUBELLA (MMR)** ☐ MENINGITIS ☐ PNEUMONIA ☐ SHINGLES ☐ TDAP ☐ *VARICELLA** ☐ OTHER (PLEASE SPECIFY):_____

	Please answer the following questions so we can assess the safety and the appropriateness of vaccination:	Yes	No
ALL VACCINES	1. Do you have a long-term health problem? If yes, please list:		
	2. Do you have a fever or illness today?		
	3. Do you have any allergies to medications, foods (e.g. eggs), latex, or a vaccine component (e.g. gelatin, neomycin, polymyxin, yeast, thimerosal, etc.)? If yes, please list what you are allergic to:_____		
	4. Have you ever had a serious reaction after receiving a vaccine? (swelling, trouble breathing, seizure, etc.)		
	5. Have you had the vaccine (s) you are receiving today before?		
	6. Have you experienced seizures, Guillain-Barre Syndrome, or any other neurological disorder?		
	7. Have you received any vaccines in the past 28 days? If yes, please list vaccine and date:_____		
	8. **For Women**: Are you currently pregnant, breastfeeding, or are you planning to become pregnant in the next month?		
*LIVE VACCINES	9. Do you have cancer, leukemia, lymphoma, HIV/AIDS, organ transplantation, or any other immune system problem?		
	10. In the past 3 months, have you taken medications that weaken your immune system, such as anticancer drugs, high-dose steroids, chemotherapy, injectable therapy for rheumatoid arthritis, Crohn's disease or psoriasis (e.g. Humira, Enbrel) or had radiation treatments? If yes, list medication, dose, and date last taken:_____		
	11. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, list medication, dose, and date last taken:_____		

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the parent or legal guardian of the minor Patient; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the health care provider of Harris Teeter Grocery Stores to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Harris Teeter Grocery Stores its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I authorize Harris Teeter Grocery Stores to release any medical or other information to my health care professionals, Medicare, Medicaid or other third party payor necessary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Harris Teeter Grocery Stores with respect to the vaccine(s) listed above.

✘ _____ **Date:** _____

(SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF PATIENT UNDER AGE 18) (FOR LEGAL GUARDIANS ONLY: PRINT NAME and RELATIONSHIP)

*** FOR INTERNAL USE ONLY *** ☐ Immunizer counseled patient to remain near location for 15-20 mins – **MUST CHECK BOX**

Vaccine Name:_____ Manufacturer:_____ Dose:_____ Series #:____ of ____ Vaccine Lot #:_____ Vaccine Exp. Date:_____ Diluent Lot #/Exp. Date:_____	Vaccine Name:_____ Manufacturer:_____ Dose:_____ Series #:____ of ____ Vaccine Lot #:_____ Vaccine Exp. Date:_____ Diluent Lot #/Exp. Date:_____	Vaccine Name:_____ Manufacturer:_____ Dose:_____ Series #:____ of ____ Vaccine Lot #:_____ Vaccine Exp. Date:_____ Diluent Lot #/Exp. Date:_____
Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given:__/__/__Version Date:__/__/__	Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given:__/__/__Version Date:__/__/__	Injection Site: **LEFT/RIGHT; ARM/THIGH** Route: **IM** or **SubQ** VIS Given:__/__/__Version Date:__/__/__

Supervising RPh/Lic#:_____ (if required)

Immunizer:_____ RPh/Intern/NP/PA/LPN/RN Date Administered:___/___/___ Time: _____AM/PM