Immunization Consent Form

HAWTHORNE
PHARMACY & MEDICAL EQUIPMENT

110 S Congress St
Winnsboro, SC 29180
803-635-3565

PATIENT'S FIRST NAME	MIDDLE INITIAL	PATIENT'S LAST NAME	DATE OF BIRTH (MM/DD/YYYY)	10-DIGIT PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

GENDER	WEIGHT	MEDICARE ID NUMBER	PRIMARY CARE PHYSICIAN NAME AND CITY
M F	<200 lbs 200-259 lbs >260 lbs		

VACCINE(S) REQUESTED (CIRCLE)	PREFERRED INJECTION SITE
COVID Influenza (flu) Pneumococcal (pneumonia) Herpes zoster (Shingles) Tetanus/diphtheria/pertussis Other: _____	Left arm Right arm

PRECAUTIONS AND CONTRAINDICATIONS

Question	Yes	No
1. Are you feeling sick today (fever, cough, diarrhea, vomiting)? If yes, list: _____		
2. Do you have allergies to latex, medications, food, eggs, or vaccines (ex// eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal (cleaning products or contact lens solution)? If yes, list: _____		
3. Have you ever felt faint or dizzy after receiving a vaccine?		
4. Have you ever had a reaction after receiving a vaccine?		
5. Do you have a long term health problem with heart, lung, liver or kidney disease; diabetes; asthma; neurologic or neuromuscular disease; anemia or other blood disorders or take a blood thinner?		
6. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, or long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?		
7. Have you ever had Guillain-Barre Syndrome, a seizure, brain or nerve problem?		
8. Women: Are you or could you become pregnant during the next 3 months?		
9. I agree to stay in the vaccine area 15 minutes to monitor for adverse reactions.		
For COVID vaccines only:		
1. Do you have a health condition or undergoing treatment that makes you moderately or severely immunocompromised (including but not limited to cancer treatment, HIV, receipt of organ transplant, immunosuppressive therapy or high dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT) or moderate/severe primary immunodeficiency		
2. Have you received a COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?		
3. Have you had an allergic reaction to a dose or component of COVID-19 vaccine?		
4. Check all that apply: ☐ History of myocarditis or pericarditis ☐ History of Multisystem Inflammatory System (MIS-C MIS-A) ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT) ☐ History of thrombosis with thrombocytopenia syndrome (TTS) ☐ Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 within the past 90 days?		
5. Have you ever had an allergic reaction to polyethylene glycol (PEG), polysorbate or a previous COVID-19 vaccine dose?		
6. Have you received dermal fillers?		
7. Previous doses of COVID-19 vaccines: Date: _____ Manufacturer (circle): Moderna Pfizer Janssen Other: _____ Date: _____ Manufacturer (circle): Moderna Pfizer Janssen Other: _____ Date: _____ Manufacturer (circle): Moderna Pfizer Janssen Other: _____ Date: _____ Manufacturer (circle): Moderna Pfizer Janssen Other: _____		
8. I understand the benefits and risks described in the Emergency Use Authorization (EUA) Fact Sheet, provided with this consent form.		
For LIVE vaccines only:		
1. Do you consider yourself to be, or have you ever been told by a physician that you are immunosuppressed?		
2. Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simpona Aria, Xeljanz, Orencia, Arava, Acterma, Cytoxan, Rituxan, adalimumab, infliximab, or etanercept), high dose methotrexate, azathioprine or mercaptopurine, antivirals, anticancer drugs, or radiation treatments?		
3. Have you received any vaccines or skin test in the past 4 weeks? List:_____		
4. Have you received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin in the past year?		
5. In the past 3 months, have you or anyone in your household taken cortisone, prednisone, other steroids, high-dose methotrexate, azathioprine, 6-mercaptopurine, antivirals, anticancer drugs or have you had any radiation treatments?		

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 the 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 immunizations. These reactions may result from hypersensitivity 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 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.

CONSENT

"I have read the adverse reactions associated with the administration of vaccines. A copy of the vaccine information sheet has been provided to me and a copy of the vaccine manufacturer's drug information sheet is available upon 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 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 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. Hawthorne Pharmacy will use and disclose your personal and health information or personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other healthcare 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:	DATE:
PRINT NAME:	

Vaccine:_____
Lot: _____ Exp:_____ Mfg: _____
Qty: _____ Site:_____ Route: _____
Rph: _____ Lic #:_____
Admin Date/VIS given:_____ VIS date: ____

Vaccine:_____
Lot: _____ Exp:_____ Mfg: _____
Qty: _____ Site:_____ Route: _____
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