

Vaccine Consent Form

Name: _____ DOB: ____ / ____ / ____ Gender: M / F Phone Number: (____) ____ - ____			
Address: _____ City: _____ State: _____ ZIP: _____			
Food/Drug Allergies: _____			
Primary Care Physician: _____ Physician Address: _____			
Medicare Part B: Y / N If yes, Name as it appears on Card: _____			
Medicare #: (____ - ____ - ____) I consent to the administration of the following vaccine(s):			
☐ Flu Shot ☐ High Dose ☐ Preservative Free ☐ Other: _____			
Please place an X in the box to help determine if the vaccine(s) may be given today			
	YES	NO	Explain
1. Are you sick today? (Do you have fever, diarrhea, or have you vomited?)			
2. Have you ever had a severe reaction to any vaccine?			
3. Are you allergic to eggs, thimerosal, Streptomycin, or neomycin?			
4. For Women: Are you pregnant or is there a chance you could become pregnant in the next month?			
5. Have you had a seizure or a brain disorder or other nervous system problem?			
6. Do you have gullain-barre syndrome? (a condition that causes paralysis)			
7. Do you have any other chronic health conditions like asthma or diabetes?			
8. Have you had a pneumococcal vaccine? (pneumonia shot)			
9-11 For Live Vaccines Only			
9. Have you had a blood transfusion or received blood products such as immune globulin in the last year?			
10. Have you received any vaccinations in the last 4 weeks?			
11. Do you or another member of your household have cancer, leukemia, HIV/AIDS, or other immune system problem?			

I have read, or have had explained to me, the information regarding the vaccine(s) marked below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and authorize the administration of the vaccine to me or the person named below for whom I am authorized to make this decision.

I, for myself, my heirs, and executors release **Melvindale Pharmacy**, Part B Specialists as the Medicare provider, any retail or external site, physician, and employees, from any and all claims arising out of, or in any way related to my receipt of this or these immunization(s). **Melvindale Pharmacy** and the aforementioned related parties shall not at any time or any extent be liable or responsible for any loss, injury, death, or damage to be suffered or sustained at any time as a result of this vaccination program.

I consent the release of this information to my Primary Care Physician as listed above to document receipt of vaccination.
I agree to wait in the vaccination location for approximately 20 minutes for observation after vaccination.

☐ *I authorize **Melvindale Pharmacy** and Part B Specialists to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Part B Specialists as my Medicare Part B provider.*

Signature: _____ Date: _____

For Pharmacy Use Only:

Vaccine Name	Mfg	Quantity (mL)	Lot #	Exp Date:	Injection Site/Route	Date Immunization/ VIS Given	Date on VIS	Date NOV Sent PCP

Vaccine Administered by: _____ Date: _____ Location: _____

Bring the completed form to Melvindale Pharmacy, 18287 Allen Rd.