West Milford
PHARMACY & GIFT

1495 Union Valley Rd.
West Milford, NJ 07480
973-728-1400

Immunization Consent Form

NAME (Last)	(First)	(M.I.)	Date of Birth ____/____/____ *month day year*
Mailing Address:		Gender ☐ Female ☐ Male	
		Phone:	
Primary Physician:		Medicare Number	

The following questions will help us determine your eligibility to be vaccinated today.	Y	N	?
1. Which vaccines are you (your child) requesting today? Please list all requested vaccines: ☐ Flu Shot ☐ Pneumonia ☐ Shingles ☐ Other:			
2. Are you currently sick with a fever?			
3. Do you have allergies to medications, food (e.g. Eggs), any vaccines and their components (e.g. neomycin), or latex?			
4. Have you ever had a serious reaction after receiving a vaccination?			
5. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
7. Do you have a parent, brother, or sister with an immune system problem?			
8. In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
9. Have you had a seizure or a brain or other nervous system problem (i.e.Guillain Barre Syndrome)?			
10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
11. Have you received any vaccinations in the past 4 weeks?			
12. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			

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. I have read, or had explained to me the Vaccine Information Statement about my vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for the public health purpose. I authorize release of vaccination information to my primary care physician. I have received a copy of the Patients Bill of Rights.

_____ _____

Signature of Recipient (Parent or Guardian) Date

Pharmacy Use Only

Vaccine:	Lot#	Exp.	Mfg:	VIS Date:	Date Given:
Dose:	Route:	Arm	Authorizing Physician:		

RPh:_____ Date Administered:_____