VACCINE INFORMED CONSENT FORM

LEWISVILLE DRUG
PHARMACY&WELLNESSCENTER

PATIENT INFORMATION

Full Name (First MI Last): _____ Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____ Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unknown

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or other Pacific Island ☐Black or African American ☐White ☐Other _____

Mother's Maiden Name: _____ Primary Care Doctor: _____ City/State: _____

INSURANCE INFORMATION *Skip if Card was Copied*

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the vaccine, administration fee, & receive payment.

Insurer: _____ Member #: _____

Rx Group: _____ BIN #: _____ PCN #: _____

VACCINE SCREENING QUESTIONS

Vaccine(s) to receive: ☐ Flu ☐ COVID-19 ☐ Pneumonia ☐ Shingles ☐ RSV ☐ Tetanus ☐ Other: _____

Date of last COVID-19 dose: _____

	YES	NO	Don't Know or N/A
Do you feel sick today?			
Have you received any immunizations in the past 4 weeks? Please specify: _____			
Do you have an allergy to any food, medication, latex, or vaccine? If so, please specify allergy: _____			
Have you ever had a serious reaction or fainted after receiving any vaccination?			
In the past 3 months, have you taken medications that affect immune system such as prednisone, other steroids, or anticancer drugs, drugs for autoimmune disease (RA, Crohn's, etc.) or had radiation?			
Do you have cancer, leukemia, HIV/AIDS, history of a transplant, or an autoimmune disorder?			
Have you ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?			
Do you have a long-term health problem with heart, lung, kidney, diabetes, asthma, no spleen, cochlear implant, anemia or a blood/bleeding disorder? If yes, please specify: _____			
FOR WOMEN: Are you pregnant or are you planning on becoming pregnant during the next month?			
FOR TETANUS: Do you have an open wound, puncture, or tissue tear that prompted you to get a tetanus shot?			

COVID-ONLY SCREENING QUESTIONS

Have you had COVID-19 within the last three months?			
Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
Do you have a history of myocarditis or pericarditis?			
Do you have a condition or are you on drugs that weaken your immune system?			
Do you have a history of immuine-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT) andor thrombosis with thrombocytopenia syndrome (TTS)?			
Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?			

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. 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 have received a copy of a current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Lewisville Drug Company, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Lewisville Drug Company to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes (or 30 minutes with history of anaphylaxis with a vaccine) for observation by the pharmacist.

SIGNATURE OF PATIENT TO RECEIVE VACCINE

(or Signature of Power of Attorney or Legal Guardian) _____ Date: _____

Guardian/ Guarantor Name: _____ Relationship to patient: _____

PHARMACY USE ONLY

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Injection Site	Date of VIS
Influenza						LD RD	01/31/2025
Pneumococcal						LD RD	05/12/2023
Herpes Zoster						LD RD	02/04/2022
Tdap						LD RD	01/31/2025
RSV						LD RD	01/31/2025
COVID-19						LD RD	01/31/2025

Administered by: _____ Date Administered: _____ Pharmacist: _____PharmD