Center Drug

PATIENT VACCINE CONSENT FORM:

Circle Shot requested: Flu Covid

Today's date:_____ Medicare #:_____

Patient Name_____

Date of Birth:____/____/____Age:_____Sex: M F Phone:_____

Address:_____

City:_____State:_____Zip:_____

Current Insurance Information (all of this information can be found on your drug insurance card):

(OR—attach a photocopy of the front and back of insurance card)

Rx Bin:_____

Rx PCN:_____

Rx Group:_____

Rx ID Number:_____

Emergency Contact:

Name:_____Phone:_____

I understand the benefits and risks of the vaccination as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine be given to me or to the person named above for whom I represent that I am authorized to sign this Consent and Release.

I hereby authorize Hopkins Center Drug to bill my insurance on my behalf for the immunization and receive payment.

_____ _____

Patient or Legal Guardian Signature **Date**

Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME _____

DATE OF BIRTH ____/____/____ (month / day / year)

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
11. Are you pregnant?	☐	☐	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
14. Are you anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Vaccine: Flucelvax Afluria Fluzone HD

Dose 0.5ml

Lot #:_____ Exp. Date:_____

Route: IM Site: Left Deltoid Right Deltoid

VIS Date: 1/31/2025 for both

Date Vaccine and VIS given:_____

Comirnaty

Dose: 0.3 ml

Lot:_____

Exp Date:_____

Route: Left Deltoid

Right Deltoid