Harris Teeter
Your Neighborhood Food & Pharmacy

Vaccine Administration Consent Form
Live and Inactivated Vaccines

HT Store #

Name: _____ Gender: **M / F** Date of Birth: ____/____/____ Phone: _____

Address: _____ City: _____ County: _____ State: _____ Zip: _____

Mother's name (first/maiden):_____ Primary Care Physician: _____

Which vaccines are you requesting to be administered today:

☐ Influenza ☐ Pneumonia ☐ Shingles ☐ Hepatitis B ☐ Tetanus/Tdap ☐ Other: _____

	Please answer the following questions:	**Yes**	**No**
ALL VACCINES	1. Are you sick today?		
	2. Do you have any allergies to medications, food (i.e. eggs), yeast, a vaccine component, or latex? **If yes**, list:		
	3. Have you ever had a serious reaction after receiving a vaccination?		
	4. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? ***Circle which apply***		
	5. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?		
	6. **For women**, are you pregnant or is there a chance you could become pregnant during the next month?		
	7. Have you received any vaccinations or TB skin test in the past 4 weeks?		
	8. Do you have a history of fainting, particularly with vaccines?		
	9. Have you ever received a pneumococcal, or "Pneumonia", vaccine?		
LIVE VACCINES ONLY	10. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (i.e. bone marrow transplant recipient)?		
	11. Do you take antiviral medications such as acyclovir, valacyclovir, and famciclovir?		
	12. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
	13. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?		
	14. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease? ***Circle which apply***		
	15. **For Zoster,** have you had a past reaction to gelatin or triple antibiotic ointment?		

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; or (iii) the legal guardian of the Patient. Further, I hereby give my consent to the health care provider of Harris Teeter Grocery Stores to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Harris Teeter Grocery Stores its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I authorize Harris Teeter Grocery Stores to release any medical or other information to my health care professionals, Medicare, Medicaid or other third party payor necessary to effectuate care or payment and request that payment of authorized benefits be made on my behalf to Harris Teeter Grocery Stores with respect to the vaccine(s) listed above.

Signature: _____ **Date:** _____

FOR PHARMACIST USE ONLY

Vaccine	**Lot #**	**Exp Date**	**Manufacturer**	**Dose**	**Route**	**Site**	**VIS Date**	**Date Given**	
								VIS	**Vaccine**
Influenza				0.5 mL	IM	L / R Deltoid			
Pneumococcal				0.5 mL	IM	L / R Deltoid			
Herpes Zoster				0.65 mL	SC	L / R Deltoid			
Tdap				0.5 mL	IM	L / R Deltoid			

Immunizing Pharmacy Name:_____ **RPh / PharmD** **Signature**: _____

Immunizing Intern Name: _____ **Signature**: _____

Date reported to PCP: _____ **Date entered into registry:** _____