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 for all vaccines:	**Yes**	**No**
1. Are you sick today?		
2. Do you have any allergies to medications, food, yeast, a vaccine component, or latex? **If yes**, list:		
3. Have you ever had a serious reaction after receiving a vaccination?		
4. Has any physician or other healthcare professional cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?		
5. 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***		
6. 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***		
7. 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?		
8. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?		
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
10. **For women**, are you pregnant or is there a chance you could become pregnant during the next month?		
11. Have you received any vaccinations or TB skin test in the past 4 weeks?		
12. Do you have a history of fainting, particularly with vaccines?		
13. **For Tdap and adult Td**, do you have a cut, injury, puncture, or open wound that prompted you to get a tetanus shot?		
14. **For Zoster,** have you had a past reaction to gelatin or triple antibiotic ointment?		
15. Have you ever received a pneumococcal, or "Pneumonia", vaccine?		

*An immunization must **NOT** be given if there is an affirmative answer to question **4** or **13**, any other affirmative answers should have clinical due diligence per protocol.*

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:** ______________