Brookshire Brothers PHARMACY

Vaccine Administration Consent Form

Please choose vaccine:

- ☐ Flu
- ☐ COVID-19
- ☐ Pneumonia
- ☐ Shingles
- ☐ Tdap
- ☐ HPV
- ☐ Hep B
- ☐ Other _____

First Name _____ MI _____ Last Name _____

Cell Phone _____ Date of Birth _____ AGE _____ Gender _____

Home Address _____ City, State, Zip Code _____

Doctor Name _____ Doctor Phone _____

Allergies _____ Medicare # (if applicable) _____ Driver's License # or Social Security # _____

Race
- ☐ White
- ☐ Black/African-American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian/Pacific Islander

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

	The following questions will help us determine your eligibility to be vaccinated today.	Yes	No	Don't Know
	1. Do you have a fever or illness today?			
	2. Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?			
	3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?			
	4. Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal)?. If yes, please list the allergies			
	5. Have you received any vaccinations or skin tests in the past 28 days? If yes, please list type & brand (if COVID). _____			
	6. Have you ever had a serious reaction to an influenza vaccine or any other vaccine in the past?			
	7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis) or other nervous system problem?			
	8. Are you 65 years of age or older?			
	9. Do you smoke?			
	10. Do you have a chronic condition or long-term health problem? If yes, please circle all that apply. Anemia Asthma Diabetes Heart disease Kidney disease Liver disease Lung disease Other			
	11. If you answered YES to question #8, 9 or 10, have you ever had a pneumonia vaccination?			
	12. Have you ever had a shingles vaccination (for patients 50 years of age and older only)?			
	13. For women: Are you pregnant, lactating, or considering becoming pregnant in the next month?			
LIVE VACCINES	14. For the past 3 months, have you taken medications that affect your immune system, such as prednisone or other steroids, anti- cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?			
LIVE VACCINES	15. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyonewho has a severely weakened immune system?			
LIVE VACCINES	16. Have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?			
LIVE VACCINES	17. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)			

I request that the vaccine(s) checked above be administered to me or the person named below whom I am authorized to make this decision for. I agree to remain at the clinic for at least 15 minutes after receiving my vaccination. I have read or have had information about this vaccine explained to me. I understand the benefits and risks associated with the vaccine and choose to assume the risk. As with all medical treatment, I realize that there is no guarantee that I will not experience an adverse side effect from the vaccine. I understand and acknowledge that the vaccine may be administered by a nursing or pharmacy student. Furthermore, I hereby release and discharge Dr. James Rick Martin and Brookshire Brothers, Inc., its affiliates and officers, board members, and employees from any and all liability for illness, injury, loss or damage which may result from this immunization. I will communicate the information given today to my primary care physician if I have one. Medicare Part B Patients: I authorize Brookshire Brothers and Allwin to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Allwin as my Medicare Part B provider.

Patient Signature: _____ Date: _____

(Parent or Guardian, if minor)

Pharmacy Use Only

Vaccine	Lot#	Expiration Date	Manufacturer	Dose (mL)	Route	Site	VIS Date

Immunizer Name & Title _____ Immunizer Signature _____ Date Administered _____

Store # _____

Texas: Fax (within 24 hrs) to Dr. Martin at (936) 634-1406 or (866) 482-4043 & to the patient's PCP as listed above within 14 days.
*If patient is a minor (under 18), fax completed form and Immtrac Consent form to Rebekah Modisette at (281) 432-8201.

☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose ☐ Booster Louisiana: Fax to the patient's PCP and enter information directly into LINKS within 24 hours.

Primary Series Completed: __/__/___