

Better Health Pharmacy LLC
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Fort Worth, TX 76123
682-708-3499

Adult Vaccine Consent and Administration Record
Pharmacist Immunization Program

_____ **M** or **F**
 Last Name First Name Date of Birth Sex

 Street City, State Zip Code Phone Number
 List any known Allergies: _____
 Describe or List any existing Medical Conditions: _____
 Primary Care Physician: _____ Phone Number: _____

<i>Please answer the following questions:</i>	Yes	No	Don't Know
1. Are you sick today? (For example: a cold, fever, acute illness) Today's date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, or any vaccine? (For example eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please list _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you take anticoagulation medication?(For example: Warfarin, Coumadin or other blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure, brain, or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please read the following statements and sign and date below.

Consent for services, HIPAA Privacy Information and Medical Records

I have been provided with the Vaccine Information Sheet (VIS) and/or been provided with information regarding to the vaccine I am receiving. I understand all the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result. I request the vaccine be given to me and authorize and direct this health care provider to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated by this provider (standing order practitioner (Dr. _____), my Primary Care Physician (PCP), my insurance plan and/or state federal registries, where required for purposes of treatment, payment or other health care operations. This only allows this provider to disclose the following medical records: only documents related to the vaccination received today. This authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse or revoke this Authorization at any time. I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice. I have acknowledged that I have received the provider's Inc Notice of Privacy Practices which may be provided at my request. For Medicare Billing: I authorize this provider to release information and request payment. I understand that the information given by me in applying for payment is correct. I authorize the release of all records to act on this request and I request that payment of benefits be made on my behalf.

Signature of patient or guardian: _____ Date: _____

This section to be completed by the Pharmacy: Vaccine Administration Information

Date	Product	Manufacturer	Vol (ml)	Route	Site
Lot #	Exp. Date	VIS Version Date	Date VIS Given to Pt	Administering Immunizer	

Patient Insurance Information: (Copy front and back of the card)
 Primary:
 Plan Name: _____ Payer ID: _____
 ID# _____ Group: _____
 Secondary:
 Plan Name: _____ Payer ID: _____
 ID# _____ Group: _____

Affix Rx Label Here