BetterHealth Pharmacy
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Children and Teens Consent & Administration Record

Pharmacist Immunization Program

For Office Use Only
☐ B

Patient Information (Vaccine Recipient):

Name (Last) (First)		**Date of Birth**	**Gender** ☐ M ☐ F
Address	**City** **State** **Zip**		**Phone Number**
Primary Care Physician:		**Provider Phone Number:**	
List Any Known Allergies:			
Describe or list any existing medical conditions:			

Screening Questions	YES	NO	Don't Know
1. Is the child sick today? (For example: a cold, fever, acute illness) Today's date: _____	☐	☐	☐
2. Does the child have allergies to medications, food, or any vaccine? (For example eggs, gelatin, neomycin, Thimerosal, latex, etc.) Please list _____	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past year?	☐	☐	☐
4. Does the child have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Has the child had a seizure, brain, or other nervous system problem?	☐	☐	☐
8. During the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. Is the child/teen pregnant?	☐	☐	☐
10. Has the child received any vaccinations in the past 4 weeks?	☐	☐	☐

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: _____

***********PHARMACY USE ONLY**********

Date	Product	Manufacturer	Vol (ml)	Route	Site

Lot #	Exp Date	VIS Version Date	Date VIS Given to Pt	Administering Immunizer

Insurance Plan Name:
ID:
Rx BIN:
PCN:
Group:

Affix RX Label Here