Fisherville Pharmacy Pneumococcal Vaccine Consent Form

THIS BOX IS FOR PHARMACY USE ONLY

Adhere RX Vaccine Label Info Here

Vaccinator's Initials

Patient Information (Vaccine Recipient):

Name		Date of Birth	Gender
Address			
City	State	Zip	Phone Number
State of Birth:	Mother's Maiden Name:		
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	Race: ☐ White ☐ African American ☐ Asian ☐ American Indian ☐ Other		

Screening Questions:

Question	YES	NO	Don't Know
1. **Are you feeling ill today, or have you been ill within the last 14 days?**	☐	☐	☐
2. **Have you ever had a serious reaction after receiving a vaccine?**	☐	☐	☐
• If yes, please provide details:_____			
3. **Have you ever had an allergic reaction to:** (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• **Eggs**	☐	☐	☐
• **Preservatives such as thimerosal or phenol**	☐	☐	☐
• **Latex**	☐	☐	☐
4. **Have you had Gullian-Barre Syndrome, a neuro-muscular condition?**	☐	☐	☐
5. **Do you have a bleeding disorder or are you taking a blood thinner (warfarin, daily aspirin)?**	☐	☐	☐
6. **Have you received a vaccine in the past 4 weeks?**	☐	☐	☐
7. **Have you received a pneumococcal vaccine before?**	☐	☐	☐
• If yes, when and which one? _____			

Consent:

I have read, or have had read to me, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Fisherville Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I certify that I am at least 18 years old and hereby give my consent to the pharmacists of Fisherville Pharmacy to administer the vaccine(s). If under 18 years old signature by parent or guardian is required. I agree to wait near the vaccination location for approximately 15 minutes for observation by the pharmacist. I understand that if I experience any side effects, it will be my responsibility to follow-up with my primary provider's office or at the health center of my choice. By authorizing the administration of the vaccine(s), I also authorize the release of this information to my primary care provider

NH Immunization Information System-The New Hampshire Immunization Information System is a secure statewide vaccine registry that connects and shares your immunization information among public clinics, private provider offices, and local health care facilities that administer immunizations and provide medical care to New Hampshire residents. By signing below, you are agreeing to Fisherville Pharmacy sharing this information to the New Hampshire immunization information system. Under state law you do have the opportunity to opt-out of the immunization registry if you wish to do so. Please request the opt-out form directly.

Signature: _____Date: _____

NHIIS
☐Opt In ☐Opt Out

Updated 8/8/2022