Vaccine Consent and Assessment

Eastridge-Phelps PHARMACY
Service you deserve from neighbors you trust

EP Medical, LLC
500 N Bypass, Suite C
Campbellsville, KY 42718

First Name:	MI:	Last Name:		
Home Phone: ( )	Date of Birth: / /	Age:	Weight:	Gender:
Home Address:		City:	State:	Zip:
Primary Care Provider:				

I WANT TO BE PROTECTED FROM THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ HPV ☐ Measles/Mumps/Rubella (MMR) ☐ Meningitis ☐ Pneumonia
☐ Shingles ☐ Tetanus, Diphtheria, +/- Pertussis ☐ Varicella ☐ RSV ☐ Other: _____

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
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?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that affect you immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
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?	☐	☐	☐
9. For Women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

I hereby give my consent to the pharmacist of Eastridge-Phelps Pharmacy/E.P. Medical, LLC, to administer the vaccine(s) I have requested. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine or medication. I fully release and hold harmless Eastridge-Phelps Pharmacy/E.P. Medical, LLC, its pharmacists, and employees from any and all liabilities or claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) given. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize Eastridge-Phelps Pharmacy/E.P. Medical, LLC to submit a claim for reimbursement on my behalf to Medicare or any other contracted third-party payer. If the claim is denied, I understand that I will be responsible for payment. I acknowledge that I have received a copy of the Eastridge-Phelps Pharmacy Notice of Privacy Practices. Furthermore, **I agree to remain near the vaccination location for approximately 15-20 minutes after administration for observation by the administering pharmacist.**

✗ _____ Date: _____
(Signature of Patient or Parent/Guardian)

(For Pharmacy Use Only) The following section is to be completed by the pharmacy.

Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp: _____ Diluent Lot/Exp: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp: _____ Diluent Lot/Exp: _____	Vaccine Name: _____ Manufacturer: _____ Dose: _____ Vaccine Lot#: _____ Vaccine Exp: _____ Diluent Lot/Exp: _____
Injection Site: LEFT ARM RIGHT ARM **Route: IM SubQ** Immunizer: _____ Date Given/VIS Given: _____/_____/_____ VIS Version Date: _____/_____/_____	**Injection Site: LEFT ARM RIGHT ARM** **Route: IM SubQ** Immunizer: _____ Date Given/VIS Given: _____/_____/_____ VIS Version Date: _____/_____/_____	**Injection Site: LEFT ARM RIGHT ARM** **Route: IM SubQ** Immunizer: _____ Date Given/VIS Given: _____/_____/_____ VIS Version Date: _____/_____/_____