Riverview Pharmacy & Surgicals

caring for a healthy tommorow

410 eastern blvd, Essex md 21221 Ph:443-231-5177, fax:443-231-5325

Email:riverviewrx@gmail.com

VACCINE ADMINISTRATION RECORD-INFORMED CONSENT FOR VACCINATION

Section-A (Please print Clearly)

Date: ……………………

First Name: ……………………………….Middle Name: …………………………………Last Name:……………………….

Home Adress: …………………………..City,State: ………………………………………..Zip Code:…………………………

Date Of Birth: ………………………………. Age: ……………………………. Gender: Male/Female

E-Mail: …………………………………………………… Phone No:………………………………………………………………….

Name Of Your Primary Care Physician:………………………………………………………………………………………

Physician Office Adress: ………………………………….. City,State: ……………………………….Zip code: ………….

Tick Type Of Vaccine required: Flu Shot/ Pneumonia/Other: Specify…………………………………………..

Section-B

Please Answer the Following Questions to help us determine your eligibility to be vaccinated today

For All Vaccination: Complete Question 1 through 8;For Live Vaccination : Complete Que. 1 through

For All Vaccinations	Yes	No	Don't Know
1. Do you feel sick today?			
2. Do you have allergies to any medications, food/ any vaccine?(Ex. Eggs, Gentamicin)			
3. Have you received any vaccinations in the past 4 weeks? If yes, please list these:			
4. Have you ever had a serious reaction after receiving a vaccination?			
5. Do you have a neurological disorder such as seizures or other types of brain disorders, Guillan-Barre Syndrome?			
6. Are you 65 years of age or older OR do you smoke OR have chronic conditions such as Asthma or Diabetes?			
7. If you answered YES to question #6, have you ever had a "pneumonia" (Pneumococcal) vaccination?			
8. For women: Are you pregnant /considering becoming pregnant in the next 3 months?			
For Live Vaccination			
9. Do you have cancer, leukemia, AIDS, or any other immune system problem?			
10. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have had radiation treatments?			
11. Are you currently on any weekly injection medications such as Humira, Remicade, Enbrel, Kineret?			

12. Have you received a transfusion of blood or blood products, or a medicine called immune (gamma) globulin?			

I understand that it is highly advisable to WAIT near the vaccination location for 15-20minutes after receiving the vaccine.

I have had a chance to ask questions that were answered to my satisfaction about the vaccine, and how the vaccine is to be given. I understand the benefits and risk of the vaccine and authorize the healthcare provider to administer the vaccine. I hereby irrevocably agree to release Savings Pharmacy and Surgical Supplies, its employees, agents and representatives from any and all liability associated with the provision of the vaccine, including all losses, claims, damages, liabilities, and costs (including attorney's fees) incurred by me at any time following the receipt of any vaccine.

I authorize the pharmacist to send copies of my vaccine records to my Primary Care Physician

I prohibit the pharmacist from sending copies of my vaccine records to my Primary Care Physician

Patient Name: ………………………………………………… **Patient Signature:** ……………………………………..

Pharmacist Name: …………………………………………….. **Pharmacist Signature:** ……………………………….

Vaccine:
Manufacturer:
Lot #:
Exp Date:
Site & Dose:

Riverview Pharmacy & Surgicals

caring for a healthy tommorow

410 eastern blvd, Essex md 21221 Ph:443-231-5177, fax:443-231-5325
Email:riverviewrx@gmail.com