Jefferson PHARMACY

# Vaccine Waiver

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|---|---|
| Name: | DOB: Age: |
| Address: | Allergies: |
| City/State/Zip: | Chronic Diseases: |
| Phone: | Physician: |
| Male or Female (circle one) | Current Meds: |

| **The following questions will help us determine which vaccines may be given to you today. Please check the appropriate answer. If a question is not clear, please ask us to explain it.** | **YES** | **NO** | **NOT SURE** |
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| 1. Are you sick today, or have you had a fever or infection within the past 72 hours? | | | |
| 2. Do you have allergies to eggs, thimerosal, any vaccine, or any vaccine component? | | | |
| 3. Have you ever had a serious reaction after receiving a vaccination? | | | |
| 4. Do you have a history of asthma, diabetes, or any heart or lung disease? | | | |
| 5. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, hepatitis, or any other immune system problem? | | | |
| 6. Do you, any person who lives with you, or any person you take care of take cortisone, prednisone, other steroids, anticancer drugs or X-ray treatments? | | | |
| 7. Have you taken antivirals within the past 48 hours? | | | |
| 8. If 5 to 17 years of age, are you currently taking aspirin or any aspirin-containing products? | | | |
| 9. For women: Is it possible that you are pregnant or may become pregnant in the next 4 weeks? | | | |
| 10. Do you have a known history of Guillain-Barre Syndrome? | | | |
| 11. Have you received any vaccinations in the past 4 weeks? | | | |

I certify that I am at least 18 years old and hereby give my consent to the staff at Jefferson Pharmacy to administer the vaccine(s) listed below. I understand that it is not possible to predict all possible side effects or complications associated with vaccines. I, on behalf of myself, my heirs, executors, personal representatives, agents, successors and assigns hereby agree to release indemnify and hold harmless Jefferson Pharmacy and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccines listed below. If under 18 years old, signature of legal guardian is required.

Jefferson Pharmacy will not be notifying your physician of your receipt of influenza or pneumonia vaccine due to the high volume of immunizations given at this time. Please notify your physician at your earliest convenience if instructed to do so. Thanks for your cooperation. Immunization information is protected health information as required by HIPAA. I have also received the information on possible side effects and the following vaccine information statements. I agree to wait near the vaccination location for approximately 10 to 15 minutes for observation by a pharmacist.

**Signature _____ Date ____/_____/_____**

**"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jefferson Pharmacy for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services." Signature _____ Date ____/_____/_____**

| Date | Vaccine Name and Manufacturer | Lot# and Exp. Date | Dose and Site | Administered by (and Title) | VIS Date |
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