1550 S Pioneer Way, Ste 105
Moses Lake, WA 98837
Ph: 509-765-8891 Fx: 509-765-4280

Vaccine Administration Record and Consent Form

TO BE COMPLETED BY PATIENT:

Patient Name: ____

Date of Birth: __________ Age: _____ Phone# _________________ Address: ___________________________

City: ____________________________ State: _____ Zip:_________ Gender: Male or Female

Email Address _____________________________

Which vaccine(s) would you like to receive today? ____

List any medical conditions:____

Primary Care Physician __________________________________ PCP Phone: ____________________

Clinic address_____________________________ City _________________________ State______ Zip Code________

The following questions will help us determine your eligibility to be vaccinated today. If a question is not clear, please ask your pharmacist to explain it.	Yes	No	Don't Know
Are you sick today?			
Do you have any health conditions such as heart disease, kidney disease, diabetes, anemia or other blood disorders?			
Have you received any vaccinations in the past 4 weeks?			
Do you have allergies to medications, foods, latex or any vaccine component? Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)?			
Do you have a long term health problem with lung disease or asthma? Do you smoke?			
Have you ever had a seizure disorder for which you take seizure medication, a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?			
Have you ever had a serious reaction after receiving a vaccination? (including fainting or feeling dizzy)			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Do you have cancer, leukemia, AIDS, or any other immune system problem?			
Are you a parent, family member, or caregiver to a new born infant?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Have you had any of the following vaccines?	**Yes**	**No**	**Don't Know**
• **Pneumococcal Vaccine (Prevnar 13 or Pneumovax 23)**			
• **Shingles Vaccine (Shingrix)**			
• **Whooping Cough Vaccine (Tdap)**			
Did you bring your Vaccine Record Card with you today?			

I the patient or guardian of the minor patient, authorize the release of any medical information with respect to this vaccine to my primary care physician or insurance company or other payer as needed and request payment of authorized benefits to be made on my behalf to Laketown Pharmacy, PLLC

I acknowledge that the pharmacist recommends that all vaccinated patients by the providers at Laketown Pharmacy should remain in the waiting area for at least 15 minutes after the administration of the immunization. I further acknowledge that I have read, or have had read to me the Vaccination Information Sheet regarding the vaccine or vaccines I have requested. I have had the opportunity to ask questions and were answered to my satisfaction. I fully understand the benefits and risks of the vaccine or vaccines.

I consent to the provider at Laketown Pharmacy the administration of the requested vaccine or vaccines. I fully release and discharge Laketown Pharmacy, PLLC and its employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature ____ **DATE:**_________________

(Parent or guardian, if minor)

GUARDIAN NAME____

THIS SECTION FOR PHARMACY USE ONLY

Lot #____________ Exp.Date______________

Injection Site: Right Arm or Left Arm

Lot #____________ Exp.Date______________

Injection Site: Right Arm or Left Arm

Mark DuVall, PharmD

License #: PH60024043 NPI #: 1497086847

x____________________________Date: __________

Miranda Andrews, PharmD

License #: PH60232307 NPI #: 1972886851

x____________________________Date: __________