

Vaccine Documentation/ Consent Form

I hereby give my consent to the health care provider of Rollins Care Pharmacy to administer the vaccine(s) I have requested Below. 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) or the FDA's Emergency Use Authorization (EUA) 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. I understand that the information contained on this form may be shared with the state health division 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 Rollins Care Pharmacy to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. Furthermore, I agree to remain near the vaccination location for approximately 15-30 minutes after administration for observation by the administering Healthcare Provider.

Which Vaccine are you interested in getting?

- Flu
- RSV
- COVID
- Shingles
- Pneumonia
- Other please specify: _____



Signature of Patient or Parent/Guardian

Date

PATIENT INFORMATION

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Patient's Last Name:	Patient's First Name:	Phone Number:	Age:	Birth date:
Street Address:	City:	County:	State:	Zip Code:

IMMUNIZATION SCREENING QUESTIONNAIRE

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1. Is the patient to be vaccinated currently sick or experiencing a high fever?	__yes __no
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	__yes __no
3. Has the patient had a serious reaction to a vaccine in the past?	__yes __no
4. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	__yes __no
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	__yes __no
6. If the patient is a baby, have you ever been told he or she has had intussusceptions?	__yes __no
7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	__yes __no
8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem	__yes __no
9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	__yes __no
10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	__yes __no
11. Is the patient pregnant or is there a chance she could become pregnant during the next month?	__yes __no
12. Has the patient received vaccinations in the past 4 weeks?	__yes __no