ADULT VACCINE CONSENT FORM

PATIENT INFORMATION

First Name | Last Name

Date of Birth (*MM/DD/YYYY*) | Age | Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer Not to Say

Home Address | Zip Code

Phone # | Mother's Maiden Name

RACE OR ETHNICITY (Choose all that apply)

☐ Asian ☐ Black or African American ☐ White ☐ Other Race ☐ Hispanic or Latino

☐ Native American/Alaskan Native ☐ Native Hawaiian or Other Pacific Islander

CHOOSE VACCINE(S):

COVID: Moderna or Pfizer Influenza Shingles Pneumonia RSV Tdap Other: _____

MEDICAL QUESTIONS - YOU MUST ANSWER EVERY QUESTION

		YES	NO
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 vaccine?	☐	☐
4	Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (i.e. Diabetes, asthma, a blood disorder, no spleen, a cochlear implant or spinal fluid leak?	☐	☐
5	Do you have cancer, leukemia, HIV/AIDs or any other immune system problem?	☐	☐
6	Do you have a parent, brother or sister with immune system problems?	☐	☐
7	In the past 6 months, have you taken medications that affect your 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?	☐	☐
8	Have you had a seizure? Brain disorder or other nervous system problem?	☐	☐
9	Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after a COVID infection?	☐	☐
10	In the past year, have you received immune globulin, blood products or antiviral drugs?	☐	☐
11	Are you pregnant?	☐	☐
12	Have you received any vaccinations in the past 4 weeks?	☐	☐
13	Have you ever felt dizzy or faint before, during or after a shot?	☐	☐

SIGNATURE AND CONSENT

- I have read or had explained to me the current Vaccine Information Statements (VIS) and understand the benefits and risks of the vaccines.
- I have read or received a copy of the AndersonRx Notice of Privacy Practices

Signature

Date

AndersonRx Privacy Practices: *Your health information is confidential and is protected by law. It is our responsibility to protect this information as required by law and to provide you with a Notice of Privacy Practices. You may find a complete copy at www.andersonrxpharmacy.com or ask for a copy from AndersonRx.*

Pharmacy Use Only **CAIR ID#** DE-012245

Date	Vaccine Mfg	Lot/Expiration	Admin by/Title	License #	Route IM
					Left Right
VIS Date:		**Admin Time:**		**Release Time:**	