



Vaccine Administration Record Informed Consent

Information about patient receiving the vaccination (Please print):

First Name: _____ Last Name: _____ MI _____ Date of Birth: _____ Age: _____
 Gender: _____ Medicare Number(If Applicable): _____ Phone: _____ Physician: _____
 Address: _____ City: _____ State: _____ Zip: _____

Mother's Maiden Name: _____

Race (check one): Native American or Alaska Native Asian Black or African American Pacific Islander or Native Hawaiian
 White Other

Ethnicity (check one): Hispanic or Latino NOT Hispanic or Latino

I want to receive the following immunization(s):

- Shingrix (herpes zoster) Pneumovax23 Prevnar20 RSV COVID-19
 Flu (Influenza) Flu (Influenza) High Dose (≥65 years old) Tetanus (TdaP)

The following questions will help us determine your eligibility to be vaccinated today.

All Vaccines	YES	NO	UNKNOWN
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies or reactions to medications, foods, latex, or any vaccine component? If so, please list _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, metabolic disease, active tuberculosis, anemia, or any other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have an immunocompromising condition (cancer, leukemia, AIDS, transplant) functional or anatomic asplenia, CSF leak or cochlear implant? Are you currently receiving any immunosuppressive therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a seizure, or been diagnosed with Guillain-Barre syndrome, or a nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. For women: Are you pregnant or could you become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Informed Consent, Waiver, and Notice of Privacy Practices:

I hereby consent to engage in the vaccine service I have requested above. I am aware of the side effects of the vaccine(s) and request that it be given to me. Mathis Drug Store is not responsible for assuring that I have consulted with my physician regarding my receipt of vaccine(s). In consideration of the vaccine(s) to be administered to me by Mathis Drug Store, I hereby assume all risks in connection with my participation and agree to hold Mathis Drug Store, each of its officers, directors, agents and employees harmless from all injuries, claims, losses, damages, or liability arising out of or in any way connected with my participation in this service. I hereby waive for myself, my heirs, executors and administrators all rights and claims for my participation in this program.

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Date

This section to be completed by Pharmacy Staff

Vaccine	Route	Dose	Manufacturer	Lot #	Expiration	VIS
Arexvy	IM	0.5ml	GlaxoSmithKline			07/24/23
			<i>Diluent</i>			-
Boostrix	IM	0.5ml	GlaxoSmithKline			08/06/21
Fluad HD quad	IM	0.7ml	Sanofi	370275	05/02/24	08/06/21
Flucelvax (quad)	IM	0.5ml	Sanofi	370664	06/30/24	08/06/21
Pneumovax23	IM	0.5ml	Merck			10/30/19
Pevnar20	IM	0.5ml	Pfizer			05/12/23
Shingrix	IM	0.5ml	GlaxoSmithKline			02/04/22
Shot ___ of 2 dose series			<i>Diluent</i>			-
Spikevax	IM	0.5ml	Moderna	3030372	04/22/24	10/19/23

Immunization Site:

Right Arm

Left Arm

Administering Immunizer Name and License Number

Date

Supervising Pharmacist and License Number