CONSENT AND RELEASE - INJECTABLE VACCINATIONS

Vaccine(s) Requested: **Injection Site: LD RD LPLUA RPLUA**

_____ ____/ ____/_____ (____) ❒ M ❒ F

Last Name of Patient **First** **Middle** **Birth Date** **Age** **Gender**

_____ (_____)_____-_____

Permanent Address **City** **State** **Zip** **Home Phone**

_____/ _____ _____ _____

Primary Insurance **Insurance ID # or Medicare B Number** *(Include numbers and letters)* **Primary Care Physician** **Phone #**

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Safeway Inc., on behalf of its pharmacy operations in all divisions, ("Safeway") has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Safeway, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Safeway permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Safeway to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Safeway and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Safeway in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

X_____ _____ _____

Signature of Person to Receive Vaccine(s)/Parent or Guardian of Minor Date Print Name of Parent or Guardian/ Phone #

By checking this box ❒ I authorize the administration of vaccine(s) by an immunization trained student pharmacist
By checking this box ❒ I acknowledge that I have been advised that I should remain in the area for 15 minutes observation after vaccination, however I am declining to wait.
By checking this box ❒ I acknowledge that I have been counselled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment.

		Please answer these questions by checking the boxes. If the question is not clear, please ask your pharmacist.	**Yes**	**No**	**Don't Know**
Vaccine History	**1**	All Patients: How long has it been since your last TETANUS shot?	___ yrs		❒
	2	Please check all that apply to you: ❒ Asthma ❒ Diabetes ❒ Heart Disease ❒ Tobacco Smoker ❒ 65 years or older If you checked any of the above, have you ever received the Pneumonia Vaccine? If yes, when?	❒	❒	❒
	3	Patients 60 years of age or older: Have you ever received the SHINGLES vaccine?	❒	❒	❒
All	**4**	Are you sick today?	❒	❒	❒
	5	Do you have a serious allergy to ANY medications or food? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin). If Yes, please list:	❒	❒	❒
	6	Have you ever had a serious reaction or fainted after receiving any vaccination?	❒	❒	❒
	7	Do you have sensitivity to latex? (Example: gloves or bandages)	❒	❒	❒
	8	For women: Are you pregnant or are you considering becoming pregnant?	❒	❒	❒
Tdap	**9**	Do you have a seizure disorder or a brain disorder?	❒	❒	❒
Live	**10**	Have you received any vaccination in the past 4 weeks? Which one(s)?	❒	❒	❒
	11	Do you have cancer, leukemia, HIV, active shingles or any other immune system problem?	❒	❒	❒
	12	Do you take prednisone, oral steroids, anticancer or antiviral drugs or medications that affect the immune system?	❒	❒	❒
	13	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?	❒	❒	❒

----------BELOW LINE FOR PHARMACY USE ONLY----------

Check Box to Confirm Patient Identity Verified ❒ **Check Box to Confirm Vaccine / Drug to be administered Verified** ❒

Vaccine	**Lot# of Vaccine**	**Exp Date**	**Manufacturer**	**Dosage**	**Site of Injection**	**Time**	**VIS Date**
Influenza (Seasonal)				0.5mL	IM L / R Deltoid		July 2015
Fluzone HD® (≥65 yrs)			Sanofi	0.5mL	IM L / R Deltoid		July 2015
Zostavax®			Merck	0.65mL	SC L / R PLUA		Oct 6, 2009

Signature of Pharmacist: _____RPh _____Intern Initials **Date VIS provided to patient: _____**

Date / Time Faxed to MD _____ / _____ AM / PM **Counseling: Accepted _____ Declined _____**