UNITED PHARMACY CLINICAL SERVICES

IMMUNIZATION CONSENT

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ Phone #:(____)_____ Primary Physician (If known) _____

MEDICARE RECIPIENTS: (We will need a copy of your card)
Do you have a Medicare Advantage plan? ☐Yes ☐No

UNITED FAMILY TEAM MEMBER #: _____
Store or Location: _____ Are you a dependent?:☐Y ☐N

FLU: ☐ Fluzone Quadrivalent (4 strain) ☐ Fluzone HD (high dose) ☐ Flumist (nasal) ☐ Fluvirin (3 strain) ☐ Flublok (egg free)

Older Adults: ☐ Prevnar 13 ☐ Pneumovax 23 ☐ Shingles

Adolescents and young Adults: ☐ HPV ☐ Meningitis

Routine: ☐ Td (tetanus) ☐ Hep A ☐ Hep B ☐ Hep A & B ☐ MMR ☐ Varicella ☐ Polio ☐ Rabies

Families with babies or contact with young children: ☐ Tdap (whooping cough)

Travel: ☐ Yellow Fever ☐ Typhoid (oral) ☐ Typhoid (shot) ☐ Japanese Encephalitis

Work: ☐ TB skin test ☐ **Other:** _____

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE:

☐ Yes ☐ No Have you ever had an allergy or serious reaction to latex, eggs, vaccines or any medications?
If yes please specify allergy or reaction: _____

☐ Yes ☐ No Do you have any long term heath conditions or smoke? Please list conditions: _____

☐ Yes ☐ No Do you weigh less than 66 lbs?

☐ Yes ☐ No If you are diabetic, have you received the hepatitis B series of vaccinations?

☐ Yes ☐ No ***For WOMEN:*** Are you currently breastfeeding, pregnant or planning to become pregnant in the next month?

☐ Yes ☐ No If you are over 65 years of age have you received ***BOTH*** pneumonia vaccines?

☐ Yes ☐ No If you are over 60 years of age have you received a shingles vaccine?

☐ Yes ☐ No Have you had any ***LIVE*** vaccinations in the past 4 weeks? (ex: MMR, Varicella, Shingles, FluMist or Yellow Fever)

☐ Yes ☐ No Have you taken an antiviral medication within the past 48 hours? (i.e. Tamiflu, Valtrex, Famvir, acyclovir)

☐ Yes ☐ No Are your currently taking any medications that may thin the blood and increase bleeding?

☐ Yes ☐ No Have you experienced a fever (>100.5), nausea, vomiting or diarrhea within the past 24 hours?

☐ Yes ☐ No Are you currently taking steroid therapy, chemotherapy, radiation treatments, or medications for rheumatoid arthritis?

I verify I have answered the questions above accurately and to the best of my knowledge. I have been provided access to a copy of United Supermarket Pharmacy's Notice of Privacy Practices & the Vaccine Information Statement for the vaccine(s) I will receive today. I understand the benefits and risks of receiving this immunization, and have been given the opportunity to ask any questions. I hereby release United Supermarkets, LLC, and all officers, directors and employees from any and all liability arising from or in any way connected with this immunization. I hereby request that the above named immunization(s) be given to me or to the person named above for whom I am authorized to sign.

Signature _____ Date _____

PLACE Rx LABEL HERE

CLINIC: _____ PRICE MODIFY: ☐ Y ☐ N

FOR PHARMACY USE ONLY

Medicare #:

PAID: $ ☐ Cash ☐ Credit ☐ Account

Vaccine	Lot	Exp	Site	¹L{5!¤9
1st:			R/L	
2nd:			R/L	
3rd:			R/L	
4th:			R/L	
5th:				

Administered by: _____ 6/2014