Costus Medical & Pharmacy Clinical Services

Immunization Consent Form

Which vaccine(s) are you requesting today? (check all that apply)

☐Flu (Influenza)	☐Shingles (Shingrix)	☐Pneumococcal (Prevnar)
☐Flu (65+ years old)	☐HPV (Gardasil)	☐TDaP (Boostrix/Adacel)
☐Hep. A (Havrix)	☐Hep. B (Engerix-B)	☐Meningococcal (Menquadfi)
☐Varicella (Varivax)	☐RSV (Abrysvo)	☐COVID-19 (1st / 2nd / 3rd / Boost)
☐M-M-R	☐Other: _____	

Patient Name: _____ Date of Birth: ___/____/ _____
First MI Last MM/DD/YYYY

Sex: • M • F Phone: (_____)_____ Email Address: _____
(Optional)

Address: _____
Street or P.O. Box City State Zip

Primary Physician: _____ Payment Method: • Private Pay • Insurance (enter below)

Insurance Carrier: _____ ID#: _____ Group#: _____

The following questions will help determine your eligibility to be vaccinated today.	YES	NO
1. Do you feel sick today? If yes, please explain:		
2. Do you have allergies to medications, food, latex, or vaccines? (For example: eggs, gelatin, gentamicin, neomycin, or thimerosal) If so, please list:		
3. Have you received any vaccinations in the past four weeks? If so, please list:		
4. Have you ever had a serious reaction to any vaccine in the past?		
5. Are you currently on home infusions, weekly injections, steroid therapy, anticancer drugs, or radiation treatments?		
6. Do you have cancer, leukemia, lymphoma, HIV/AIDS, or any other immune system disorder?		
7. Have you received a transfusion of blood or blood products in the past year?		
8. For women: Are you pregnant or considering becoming pregnant in the next month?		

Notes: _____

Place Rx Label Here

For Clinic Use Only

Clinic Name: Family Pharmacy
Date of Vaccination: _____
Manufacturer: _____
Lot#: _____ Exp Date: _____
Injection Site: _____
VIS Publication Date: _____
Administered By: _____

I certify that I am the patient and at least 18 years of age, or the legal guardian of the patient. Further, I give my consent to the healthcare provider of Family Pharmacy to administer the vaccine(s) I have requested above. I have been given a Vaccine Information Statement for each of the vaccines that I will receive today. I understand the benefits and risks of receiving the above vaccine(s), and I have been given the opportunity to ask any questions that I may have. I hereby release Family Pharmacy and all officers, directors, and employees from any and all liability arising from or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I have received or reviewed a copy of Family Pharmacy's Notice of Privacy Practices.

_____ _____ _____

Signature: _ _ Date: