Brookshire Brothers PHARMACY

VACCINE CONSENT FORM

I request that the _____ vaccine be administered to me or the person named below whom I am authorized to make this decision for. I agree to remain at the clinic for at least 10 minutes after receiving my vaccination. I have read or have had information about this vaccine explained to me. I understand the benefits and risks associated with the vaccine and choose to assume the risk. As with all medical treatment, I realize that there is no guarantee that I will not experience an adverse side effect from the vaccine. Furthermore, I hereby release and discharge Dr. James Rick Martin and Brookshire Brothers, Inc., its affiliates and officers, board members, and employees from any and all liability for illness, injury, loss or damage which may result from this immunization. I will communicate the information given today to my primary care physician if I have one.

****For Medicare Part B card holders:** PLEASE PRINT YOUR NAME AND MEDICARE NUMBER **EXACTLY** AS IT APPEARS ON YOUR CARD.

(*Please Print*) First Name_____Middle Initial____Last Name_____

Medicare Part B Card ID#_____(*including the letter at end of number)*

Street Address:_____

City:_____State:_____Zip Code:_____Phone:_____Date of Birth:_____

Sex:_____Primary Care Physician (*First and Last Name):*_____

Physician Address:_____City:_____

Physician Telephone Number:_____Allergies_____,

Chronic Disease:_____

*Note to Medicare Part B Patients: ☐ *I authorize Brookshire Brothers and Allwin to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf to Allwin as my Medicare Part B provider.*

PATIENT SIGNATURE:_____DATE:_____

----------PHARMACY USE ONLY----------

Immunizer & Title:_____ Store#:_____ Date of VIS:_____

Drug Name:_____ Mfr: _____Lot #:_____ Exp Date:_____

Amount Administered: _____ Injection Site: *(circle one)* R or L deltoid Under 18? Y* / N *(circle one)*

Today's Date:____/____/_____ RPh Signature: _____

Please Fill Out 1 Sheet For Each Vaccination Given

Fax (within 24 hrs) to Dr. Martin at (936) 634-1406 Fax (w/in 14 days) to patient's Primary Care Physician as listed above

***If patient is a minor (under 18), fax completed form and Immtrac Consent form to Rebekah Modisette at (281) 432-8201.**

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

SCREENING QUESTIONAIRE

Please answer the questions in box 1 which are universal screening questions for all vaccinations. In additional to these questions, please also answer the questions in the box designated for the vaccination you would like to receive today. If you do not understand a question, please feel free to ask the Pharmacist to explain it to you.

Box 1:

"UNIVERSAL" VACCINE SCREENING QUESTIONS

1. Are you currently sick (please let the Pharmacist aware of any current ailments, infections, etc.)? Yes No
2. Have you ever had a serious reaction after receiving a vaccination? Yes No
3. Are you currently pregnant or is it possible you may become pregnant in the next 3 months? Yes No
4. Have you received any vaccination in the past 4 weeks (28 days)? Yes No

Box 2:

PNEUMONIA VACCINE SCREENING QUESTIONS

1. Are you allergic to phenol? Yes No
2. Have you received a pneumonia vaccine within the past 3 years? Yes No
3. Have you had a splenectomy (your spleen removed)? Yes No
4. Have you ever received chemotherapy for Hodgkin's disease? Yes No
5. Have you ever had this vaccine before? Yes No

Box 3:

HEPATITIS B VACCINE SCREENING QUESTIONS

1. Are you allergic to yeast products? Yes No
2. Have you had the Hepatitis B vaccine previously? Yes No

Note: You might be asked to wait 28 days before donating blood after getting hepatitis B vaccine. This is because the screening test could mistake vaccine in the bloodstream (which is not infectious) for hepatitis B infection.

Box 4:

MENINGITIS VACCINE CONSENT QUESTIONS

1. Do you have sensitivity to Latex? Yes No
2. Have you ever had a reaction to the Diphtheria Toxoid? Yes No
3. Have you ever had this vaccine before? Yes No

Box 5:

SHINGLES/VARICELLA VACCINE CONSENT QUESTIONS

1. Are you allergic to gelatin, the antibiotic Neomycin, or any other component of the Shingles/Varicella vaccine? Yes No
2. Do you have a weakened immune system due to any of the following? Yes No
   a. AIDS or another disease that affects the immune system
   b. Current treatment with drugs that affect the immune system, such as prolonged use of high-dose steroids
   c. Current cancer treatment such as radiation or chemotherapy
   d. Current cancer affecting the bone marrow or lymphatic system, such as leukemia or lymphoma
3. Have you ever had this vaccine before? Yes No

Box 6:

TD/TDAP VACCINE CONSENT QUESTIONS

4. Have you had a seizure or a brain or other nervous system problem? Yes No
5. Have you ever had this vaccine before? Yes No