Giant Pharmacy Informed Consent to Receive Vaccines

Name:_____ _____**Date of Birth:** _____ **Male/Female**

Street:_____ **City:**_____ **Zip:**_____

Phone:_____ **Medicare B #:**_____

Email:_____ **Physician:**_____

Hepatitis A_____	Meningococcal_____	HPV_____
Hepatitis B_____	Pneumococcal_____	Rabies_____
Varicella_____	Tetanus_____	Zoster Vaccine_____
MMR_____	**Influenza**_____	Other_____

Please answer yes or no to the following questions. If any questions are unclear, please ask for assistance.

		YES	NO
1.	Do you have a fever, diarrhea, or vomiting today?	_____	_____
2.	Are you allergic to eggs, Baker's yeast, preservatives (i.e. sulfites), thimerosal, streptomycin, neomycin, or latex)?	_____	_____
3.	Have you ever had a severe reaction to any vaccine which required medical care?	_____	_____
4.	Have you had Guillain-Barré Syndrome, a condition which causes paralysis?	_____	_____
5.	Have you had Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?	_____	_____
6.	Are you or anyone in your home, or anyone you take care of being treated with chemotherapy, radiation for cancer, have HIV/AIDS or any immune deficiency disorder?	_____	_____
7.	For women: Are you pregnant or planning a pregnancy in the next three months?	_____	_____
8.	Are you taking any blood-thinning medications (i.e. aspirin, warfarin, etc.)?	_____	_____
9.	Did you ever get a Pneumonia shot? If so when _____	_____	_____

Note: Answering yes to any of questions #1-6 may warrant referral to a physician for further evaluation to determine appropriateness of the vaccination.

I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked above. I authorize the information to be forwarded to my primary care physician, authorizing physician or local Dept. of Health if applicable. I agree to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any sided effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Giant of Maryland LLC and its parent, subsidiary and affiliates, and its officers, employees and agents, respectively, from any and all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives.

Patient Signature Date

For Office Use Only

_____	_____	_____	_____
Vaccine	**Lot#**	**Exp Date**	**Manufacturer**
_____	Right/Left Deltoid/SQ or Nasal	_____	_____
Dose (ml)	**Admin Site**	**Admin Date**	**VIS Date**

_____**Administrator**