Millbrook Pharmacy Vaccine Consent Form

_____ ___ _____ ____/_____/____ ____ M/F
First Name MI Last Name Date of Birth Age

_____ _____ _____ _____ (____) _____-_____
Address City State Zip Code Phone Number

	Please answer the following questions by checking the boxes. Only fill out the COVID-19 section if you are receiving a COVID-19 vaccine.	**Yes**	**No**	**Don't Know**
Vaccine History	Have you ever received the Tetanus vaccine in the last 10 years?			
	Are you a current smoker?			
	Do you have any chronic medical conditions? (such as Asthma, Diabetes, CHF, Immunosupression, or Asplenic)			
	Age ≥ 60, have you ever received the Shingles vaccine?			
All Vaccines	Do you feel sick today?			
	Do you have allergies to medications, food, latex, or vaccines? (such as Eggs, Thimerosal, Neomycin, Gelatin)			
	Have you ever had a severe reaction to any vaccination in the past?			
	For women: Are you pregnant or planning to become pregnant in the next month?			
Tdap	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome, or other nervous system problems?			
Live Vaccines	Have you received any vaccinations in the past 4 weeks?			
	In the past 3 months, have you taken medications to weaken your immune system? (Such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatment)			
	Do you have cancer, leukemia, HIV/AIDs, or any other immune system problem?			
	During the past year, have you received a transfusion of blood or blood products, or been given immune (globulin) globulin or an antiviral drug?			
COVID-19 Vaccine	Have you received a dose of COVID-19 vaccine? If yes, date of last dose: ____/_____/____			
	Have you ever had an allergic reaction to Polyethylene glycol (PEG), Polysorbate or a previous dose of COVID-19 vaccine?			
	Do you have a history of myocarditis or pericarditis?			
	Were you ever treated with monoclonal antibodies or convalescent serum after having COVID-19?			
	Have you ever been diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
	Do you have a bleeding disorder?			
	Do you take a blood thinner?			
	Do you have a history of heparin-induced thrombocytopenia (HIT)?			
	Have you ever received dermal fillers?			

Consent and Release

I authorize all Ladue Pharmacy, LLC records to be released and reviewed by an authorized representative of my third party payor or employer as required, to apply for Medicare payment under the Title XVIII of the Social Security Act or other applicable payor plans. I authorize this information to be released and reviewed by any Federal, State or accrediting body or agency as required by the regulatory, licensing or accrediting body. I request that payment of authorized services be made in my behalf. If applicable, I authorize all Ladue records to be released to my employer.

I agree to stay in the general area for fifteen (15) minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any side effects, it will by my responsibility to follow up with my physician at my expense. Mild local reactions may include redness, swelling, or tenderness at the site. General reactions may include fever, malaise or muscle pain occurring 6-12 hours after vaccination and can persist for 1-2 days. Severe reactions may include Guillain-Barre Syndrome or anaphylaxis.

I hereby certify that the previous history is true and complete to the best of my knowledge. I understand the benefits and risk of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I release Ladue Pharmacy, LLC, its officers, employees, and agents, from any and all liability that might arise from the vaccine on behalf of my heirs, my personal representatives, and myself. I request the vaccine(s) to be given to me or to the person named below, a minor whom I represent that I am authorized to sign this Consent and Release.

Signature: _____ Date: _____

(Parent or guardian if minor)

This notification is being provided pursuant to 338.010.13, RSMo. I understand and acknowledge the admin. of this vaccine will be entered into the ShowMeVax system administered by the MO Dept. of Health & Sr. Services unless I indicate otherwise below:

_____ Do NOT report my vaccine information to ShowMeVax.

Documentation of Vaccine Administration

_____ ___ _____ ____/_____/_____

First Name MI Last Name Date of Birth

_____ _____

Primary Care Physician Physician Address

☐ PCP name/address not provided by patient

PLEASE INDICATE WHICH ARM TO INJECT: RIGHT / LEFT

FOR CLINICAL USE ONLY DO NOT WRITE IN THIS AREA

Vaccine	Dose	Injection Site	Manufacturer	Lot #	Exp. Date	VIS Date
Influenza Quad	0.5 ml	IM Deltoid L / R				
Influenza HD	0.7 ml	IM Deltoid L / R				
Prevnar 13/20	0.5 ml	IM Deltoid L / R				
Pneumovax23	0.5 ml	IM Deltoid L / R				
Tdap Boostrix	0.5 ml	IM Deltoid L / R				
Shingrix	0.5 ml	IM Deltoid L / R				
Hepatitis A/B	1 ml	IM Deltoid L / R				
COVID-19	0.5 ml	IM Deltoid L / R				
RSV	0.5 ml	IM Deltoid L / R				

Pharmacist Signature: _____ Date Given_____