SpecialtyRx
COMMITTED TO YOUR CARE

# VACCINATION CONSENT FORM

Resident: _____ Date of Birth: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician: _____

Resident/Caregiver Education Provided by: _____

☐ Check here, if reviewed with family remotely

If checked, second staff signature: _____

**Special Precautions:**

- Consult with a prescriber for use in children under 3 years of age and pregnant people.
- Consult with a prescriber for use in individuals who are allergic to eggs, chicken feather, or chicken dander. Note: Beginning with the 2023-24 influenza season, ACIP voted that people with egg-allergy may receive any flu vaccine (egg-based or non-egg based) that is otherwise appropriate for their age and health status. Additional safety measures are no longer recommended beyond those recommended for receipt of any vaccine.
- Persons with fever should not receive this vaccine until no longer considered acutely ill.
- Persons who have received another type of vaccine within the past fourteen days should see their prescriber before receiving this vaccine.
- If you have a reaction, see your prescriber immediately. If you have any questions, please ask.

## Insurance Information: ☐NO ☐YES *(COPY OF INSURANCE IS REQUIRED)* _____

*Primary Policy Holder Name (if different than patient above)*

| **Please answer the following questions ON THE DAY of the clinic:** | |
|---|---|
| 1. Has the person receiving the vaccine ever had a severe allergic (hypersensitivity) reaction to eggs, latex, thimerosal, or any vaccine component? ***If YES, please specify:** | ☐Yes ☐No ☐I Don't Know |
| 2. Does the person receiving the vaccine have a history of Guillain-Barre syndrome or a persistent neurological illness? | ☐Yes ☐No ☐I Don't Know |
| Has the person received a live vaccine within the past 30 days (i.e. MMR, Rotarix) ***If YES, recommended to space live vaccines by > 4 weeks for full efficacy.** | ☐Yes ☐No ☐I Don't Know |
| 3. Is the person receiving the vaccine currently sick with a fever? | ☐Yes ☐No ☐I Don't Know |
| 4. Is the person receiving the vaccine currently receiving radiation, chemotherapy, or immunosuppressive therapy? | ☐Yes ☐No ☐I Don't Know |
| 5. For women of childbearing age: Is the person receiving the vaccine pregnant or considering becoming pregnant in the next month? | ☐Yes ☐No ☐I Don't Know |

I have read the above information and VIS/EUA Factsheet for my requested vaccination and have had an opportunity to ask questions. I understand the benefits and risks of my requested vaccination(s) as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

☐Influenza Vaccine (standard, recombinant, high dose, adjuvanted)
☐PPSV23 (Pneumovax) ☐ PCV15 (Vaxneuvance) ☐ PCV20 (Prevnar20) ☐ PCV21 (CAPVAXIVE)
☐Shingles [Recombinant Zoster] Vaccine (Shringrix)
☐Respiratory Syncytial Virus Vaccine (Arexy, Abryso, mRESVIA)
☐Hepatitis B (Energix-B, Recobivac HB, Heplisav-B)
☐Other

SIGNATURE: _____ DATE: _____
(Resident or Legal Guardian)

(IF LEGAL GUARDIAN, PLEASE PRINT NAME): _____

| **FOR OFFICE USE ONLY** | | |
|---|---|---|
| **Vaccine Name:** | | **Administered Date:** |
| **LOT #** | **EXP DATE:** | **Administered by:** |
| **Site: ☐Left Arm ☐Right Arm ☐Other: _____** | | **SIGNATURE** |