Vaccine Administration Record, Informed Consent for Vaccination, & Physician Notification

Mercy Pharmacy Southfork

12700 Southfork Rd. Suite 110 St. Louis, MO 63128

Phone: 636-525-4488 Fax: 636-525-4810

Patient Name:____ Date of Birth: ___________________

Address:____Phone____

Primary Care Physician: ____ Fax Number: ________________________

Physician Address: ____

Which vaccines are you requesting to have administered today? Flu Shot FluHD Pneumonia Shingles Meningitis Hepatitis A/B Diptheria/Tetanus/Pertussis Other________________

Question	Yes	No	Don't Know
1. Are you (or your child) currently sick, or running a fever?	☐	☐	☐
2. Do you have a severe allergy to eggs, latex, thimerosal, neomycin, or any ingredient of the flu or other vaccine?	☐	☐	☐
3. Have you ever had a serious reaction to any vaccine in the past?	☐	☐	☐
4. Have you received any vaccines in the past 4 weeks?	☐	☐	☐
5. Have you ever had Guillain Barre Syndrome, a seizure or brain disorder, or other nervous system disorder?	☐	☐	☐
6. Are you 65 years of age or older?	☐	☐	☐
7. Do you have a chronic condition or long term health problem? (Anemia, Asthma, Diabetes, Heart Disease, Liver Disease, Lung Disease or Kidney Disease)	☐	☐	☐
8. Do you smoke, or do you have a history of smoking?	☐	☐	☐
9. If you answered YES to question 6, 7, or 8, have you ever had a Pneumonia Vaccine?	☐	☐	☐
10. Do you have cancer or any other immune system disorder, or are in contact with anyone who has a severely weakened immune system?	☐	☐	☐
11.Are you currently receiving radiation, chemotherapy, or immunosuppressive therapy including but not limited to cortisone, prednisone or other steroids?	☐	☐	☐
12. Have you received a transfusion of blood or blood products in the past year?	☐	☐	☐
13. For Women: Are you pregnant, or planning to become pregnant in the next month?	☐	☐	☐
14. For Patients under 18: Are you receiving long-term aspirin therapy?	☐	☐	☐
15. For Patients under 5: Do you have a history of asthma or wheezing?	☐	☐	☐

ShowMeVax Reporting: This notification is being provided pursuant to § 338.010.13, RSMo. I understand and acknowledge the administration of this vaccine will be entered into ShowMeVax system administered by the Missouri Department of Health and Senior Services unless I indicate otherwise below:

☐ Do NOT report my vaccine information to ShowMeVax

CONSENT FOR SERVICES, MEDICAL RECORDS, AND HIPAA PRIVACY INFORMATION

I certify that I am the patient, at least 18 years of age; or the parent/legal guardian of the minor patient; or the legal guardian of the patient. I hereby give my consent to the certified pharmacist of Mercy Pharmacy to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks & benefits associated with the above vaccine(s) & have received, read, or had explained to me the Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I also acknowledge I have had the chance to ask questions which were answered to my satisfaction. I acknowledge I was informed to remain near the vaccination location for **15 minutes** after administration for observation by the pharmacist. I hereby release & hold harmless Mercy Pharmacy & their employees from any & all liabilities & claims whether known or unknown arising out of, or in connection with administration of the vaccine(s) listed above. I authorize the release of any medical or other information necessary to process a Medicare or insurance claim, or for other public health purpose. I acknowledge that I have received a copy of the Notice of Privacy Practices of Mercy Hospital. **I further agree to be financially responsible for any co-pay, coinsurance, & deductible for the requested services due at the time of service or upon receipt of such invoice.**

Patient Signature:____**Date:** ____________________________

(Parent or guardian, if minor)

Vaccine	Lot#	Exp Date	Manufact	Dosage	Route	Site of Injection	VIS Date

Immunizer Name: _________ ___________________________ **Immunizer Signature:** ___________________________________

Administration Date & VIS given: ________________________ **Protocol Physician:** Dr Kevin King_______