VACCINE ADMINISTRATION CONSENT FORM
BROOKSHIRE GROCERY COMPANY; ENGLISH VERSION (rev 8/25/2022)

Patient Name:		**Date of Birth:** - -	**Phone:**
Address:		**City:**	**State:** **Zip:**
Primary Doctor:	**Fax #:**	**Vaccine(s) to Receive:**	

PLEASE ANSWER THE FOLLOWING QUESTIONS:

__Yes __No Are you sick today?
__Yes __No Do you have allergies to eggs, gelatin, food, neomycin, **latex**, other medications, or vaccines? **Please list:** _____
__Yes __No Have you ever had a serious reaction after receiving a vaccination? (e.g. hives, trouble breathing, or swelling of the face)
__Yes __No Do you have any or multiple of the following chronic medical conditions: chronic heart, lung, or liver disease, diabetes, alcoholism, or use tobacco products?
__Yes __No Do you have cancer, leukemia, HIV/AIDS, bone marrow disease or any other immune system problems?
__Yes __No In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation therapy?
__Yes __No Have you had a seizure, coma, brain, or other nervous system problem after a vaccine such as Guillian-Barre syndrome (an illness with sudden muscle weakness and some loss of senses in the fingers and toes)?
__Yes __No During the past year, have you received a transfusion of blood/blood products, been given immune (gamma) globulin or an antiviral drug?
__Yes __No Have you had any vaccinations in the past 4 weeks? **Please list:** _____
__Yes __No **For women:** Are you pregnant or is there a chance you could become pregnant during the next month?
__Yes __No Are you 65 years old or older? **Age:** _____

INFORMATION FOR THE PERSON TO RECEIVE THE VACCINE:

I agree that the person named above will receive the vaccine indicated and that this person will have a vaccine administered by injection to prevent infectious disease. I acknowledge that I received a current copy of the Vaccine Information Statement for this vaccine and have had the opportunity to ask questions concerning the benefits and risks of the vaccine and the diseases it prevents. ***I understand that I may be asked to stay near the pharmacy at least 15 minutes after the vaccine has been administered to ensure that no adverse reactions will occur.*** I freely and voluntarily authorize the administration of these vaccines to me or the person named above for whom I am authorized to make this decision.

By signing this form, I authorize the release of any medical or other information necessary to process this claim. I also request and authorize the payment of government benefits to the party who accepts assignment. My signature will also confirm my acknowledgement of receiving a copy of the Brookshire Grocery Company (BGC) Notice of Privacy Practices. If I decide to leave less than 15 minutes after the vaccine has been administered, my signature indicates that I will not hold any BGC employee liable for any adverse reaction that may occur outside of their supervision.

Signature of Patient or Parent/Legal Guardian (if under 18) X: _____

For Pharmacy Use Only

Has Patient's Primary Doctor Been Notified? (circle one): YES NO **Protocol Doctors: AR:** *Dr. Ked Davis* **OK:** *Dr. Ryan Hendren* **TX:** Dr. *Sean Denham*

Date: **Time:** **AM/PM** **Partner Initials:** **COVID Questionnaire Reviewed RPh Initials:**

Vaccine Type/Trade Name(s)	Dose	Manufacturer	Route	Lot #	Exp Date	Admin Site	VIS	Dose #
Influenza/*Flulaval, Fluzone, Flucelvax, Afluria, Fluarix, Fluzone HD, Flublok, Fluad*	0.25 mL/ 0.5 mL/0.7 mL	Sanofi/GSK	IM			RD LD	08/6/2021	N/A
Pneumococcal (PPSV23)/*Pneumovax23*	0.5 mL	Merck	IM/SQ			RD LD	10/30/2019	N/A
Pneumococcal (PCV20/15)/*Prevnar20/Vaxneuvance*	0.5mL	Pfizer/Merck	IM			RD LD	02/4/2022	N/A
Td/*Tenivac*	0.5 mL	Sanofi Pasteur	IM			RD LD	08/6/2021	N/A
Tdap/*Boostrix, Adacel*	0.5 mL	GSK/Sanofi	IM			RD LD	08/6/2021	N/A
Hepatitis A/*Havrix, Vaqta*	0.5mL/1 mL	GSK/Merck	IM			RD LD	10/15/2021*	
Hepatitis B/*Recombivax, Engerix, Heplisav-B*	0.5mL/1 mL	Merck/GSK	IM			RD LD	10/15/2021*	
Hep A & Hep B/*Twinrix*	1 mL	GlaxoSmithKline	IM			RD LD	*Included	
HPV/*Gardasil 9*	0.5 mL	Merck	IM			RD LD	08/6/2021	
Meningococcal ACWY /*Menquadfi, Menveo*	0.5 mL	Sanofi/Novartis	IM			RD LD	08/6/2021	N/A
Serogroup B Men /*Trumenba, Bexsero*	0.5 mL	Pfizer/GSK	IM			RD LD	08/6/2021	
Polio/*IPOL*	0.5mL	Sanofi Pasteur	IM			RD LD	08/6/2021	
Measles, Mumps, Rubella/*M-M-R II*	0.5 mL	Merck	SQ			RA LA	08/6/2021	
Typhoid/*Typhim VI*	0.5 mL	Sanofi Pasteur	IM			RD LD	10/30/2019	
Typhoid/*Vivotif*	4 Caps	Berna	Oral			Oral	10/30/2019	
Varicella/*Varivax*	0.5 mL	Merck	SQ			RA LA	08/6/2021	
Zoster/ *Shingrix*	0.5 mL	GSK	IM			RD LD	2/4/2022	
Other								

BILLING INFORMATION (circle one)

TP (See Below)	Cash	Medicare B

BIN: PCN: GRP #: ID #: PC:

(Pharmacy Stamp Here)

Immunizer Signature:
☐ Pharmacist ☐ Intern ☐ Technician

Pharmacist Signature:
(If supervising)

Printed Name of Immunizer:

Date of Vaccine/VIS Given: