

CONSENT AND RELEASE - INJECTABLE VACCINATIONS

Vaccine(s) Requested: _____	Injection Site: LD RD LPLUA RPLUA
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Last Name of Patient	First	Middle	Birth Date	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F
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Permanent Address	City	State	Zip	Home Phone
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Primary Insurance	Insurance ID # or Medicare B Number <small>(Include numbers and letters)</small>	Primary Care Physician	Phone #
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I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is provided with this Consent and Release. I confirm that Safeway Inc., on behalf of its pharmacy operations in all divisions, ("Safeway") has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Safeway, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release. I understand that I am giving Safeway permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company or immunization registry, as applicable, to enable Safeway to process my insurance claims with respect to the vaccination. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby release Safeway and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Safeway in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

X Signature of Person to Receive Vaccine(s)/Parent or Guardian of Minor _____ Date _____ Print Name of Parent or Guardian/ Phone # _____
 By checking this box I authorize the administration of vaccine(s) by an immunization trained student pharmacist

Please answer these questions by checking the boxes. If the question is not clear, please ask your pharmacist.		Yes	No	Don't Know
VaccineHistory	1	All Patients: How long has it been since your last TETANUS shot?		___ yrs <input type="checkbox"/>
	2	Please check all that apply to you: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Tobacco Smoker <input type="checkbox"/> 65 years or older If you checked any of the above, have you ever received the Pneumonia Vaccine? If yes, when?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	3	Patients 60 years of age or older: Have you ever received the SHINGLES vaccine?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
All	4	Are you sick today?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	5	Do you have a serious allergy to ANY medications or food? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin). If Yes, please list:		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	6	Have you ever had a serious reaction or fainted after receiving any vaccination?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	7	Do you have sensitivity to latex? (Example: gloves or bandages)		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Tdap	8	For women: Are you pregnant or are you considering becoming pregnant?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	9	Do you have a seizure disorder or a brain disorder?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	10	Have you received any vaccination in the past 4 weeks? Which one(s)?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Live	11	Do you have cancer, leukemia, HIV, active shingles or any other immune system problem?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	12	Do you take prednisone, oral steroids, anticancer or antiviral drugs or medications that affect the immune system?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	13	During the past year, have you received a transfusion of blood or blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

-----BELOWLINEFORPHARMACYUSEONLY-----

Check Box to Confirm Patient Identity Verified Check Box to Confirm Vaccine / Drug to be administered Verified

Vaccine	Lot# of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection	Time	VIS Date
Influenza (Seasonal)				0.5mL	IM L / R Deltoid		July 2014
Fluzone HD® (≥65 yrs)			Sanofi	0.5mL	IM L / R Deltoid		July 2014
Zostavax®			Merck	0.65mL	SC L / R PLUA		Oct 6, 2009
Pneumovax®			Merck	0.5mL	IM L / R Deltoid		Oct 6, 2009
					SC L / R PLUA		
Tdap				0.5mL	IM L / R Deltoid		May 9th 2013
					SC L / R PLUA		
					IM L / R Deltoid		
					SC L / R PLUA		

Signature of Pharmacist: _____ RPh _____ Intern Initials _____ Date VIS provided to patient: _____
 Date / Time Faxed to MD _____ / _____ AM / PM Counseling: Accepted _____ Declined _____
Ver. 1 2014 KEEP FOR TEN (10) YEARS *FILE WITH PRESCRIPTION HARDCOPIES