FOR PHARMACY USE (Date/Time/Initials)
GRITS:_____
FAXED:_____

INSURANCE INFORMATION	
BIN	ID
PCN	GRP
❑ CARDHOLDER ❑ SPOUSE ❑ DEPENDANT	

HINESVILLE PHARMACY

481 Elma G Miles Pkwy
Hinesville, GA 31313
Phone (912) 876-8125
Fax (912) 876-4378
www.hinesvillepharmacy.com

Immunization Consent Form

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	MI	GENDER (M/F)	BIRTH DATE (MM/DD/YY)
ADDRESS	CITY	STATE		ZIP
10-DIGIT PHONE NUMBER	MEDICARE ID NUMBER	MOTHER'S MAIDEN NAME		EMAIL ADDRESS
PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN PHONE/FAX			VACCINE REQUESTED

CASE HISTORY AND LISTED CONTRAINDICATIONS (Please circle YES, NO, or DON'T KNOW for each question)

ALL VACCINES

1. Have you had a physical examination within the past year?.....YES NO DON'T KNOW
2. Are you sick today?.....YES NO DON'T KNOW
3. Do you have allergies to medications, eggs or other food, a vaccine component, or latex?.....YES NO DON'T KNOW
   If yes, list allergies_____
4. Have you ever had a serious reaction after receiving a vaccination?.....YES NO DON'T KNOW
5. Do you have long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorders? .....YES NO DON'T KNOW
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?.....YES NO DON'T KNOW
7. Have you had a seizure, brain disorder, Guillain-Barre Syndrome or other nerve problem?.....YES NO DON'T KNOW

LIVE VACCINES

8. In the past 3 months, have you taken any medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?.....YES NO DON'T KNOW
9. During the past year, have you received a transfusion of blood or blood products, or been given an immune (gamma) globulin or an antiviral drug .....YES NO DON'T KNOW
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?..... .....YES NO DON'T KNOW
11. Have you received any vaccinations in the past 4 weeks? .....YES NO DON'T KNOW
    If yes, what vaccines? _____
    _____

I have read or have had explained to me, the information in the Vaccine Information Statements for the vaccine[s] indicated. I have had an opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine[s] being requested and authorize the administration of the vaccine[s] indicated to be given to me or the person named for whom I am authorized to make this request.

For Patients receiving Live Vaccines only: I further certify that I have read the list of contraindications to the vaccine[s] set forth above and neither me or my Ward have a contraindication to the vaccine[s] to be administered.

_____ _____

SIGNATURE/LEGAL GUARDIAN DATE OF VACCINATION/DATE VIS GIVEN

_____

PRINT

ADMINISTRATIVE RECORD (For Pharmacy Use ONLY)

VACCINE	MANUFACTURER	VACCINE ADMINISTRATOR	TITLE
LOT NUMBER	EXPIRATION DATE	❑ Alex Tucker ❑ Jodie Tucker ❑ John Mark Carter ❑ Samantha Kerr ❑ Bradley Gay ❑ Other_____	❑ Pharmacist ❑ Pharmacist Intern
DOSE ❑ 0.5 ML ❑ OTHER _____	DATE NEXT VACCINE DUE (if applicable)		
ROUTE OF ADMINISTRATION ❑ IM ❑ SQ ❑ Other_____	SITE OF INJECTION ❑ LA ❑ RA ❑ Other_____	SIGNATURE	DATE ADMINISTERED

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To: Date: _____

Dr. _____

Fax: _____

Subject: Notification of Vaccination

A mutual patient has recently received one or more vaccinations at our pharmacy. This letter serves to notify you which vaccination[s] he/she has received. All vaccinations are reported to the Georgia Registry of Immunization Transactions and Services (GRITS) database. Please contact us if you have any questions.

Regards,

Hinesville Pharmacy

Patient Name: _____ **DOB:** _____

Date Administered: _____

Vaccine[s] Administered

- ❑ HPV (Human Papillomavirus) (Gardasil 9)
- ❑ IIV4 (Inactivated Influenza Vaccine Quadrivalent) (Afluria, Flucelvax)
- ❑ PCV13 (Pneumococcal Conjugate Vaccine) (Prevnar 13)
- ❑ PPSV23 (Pneumococcal Polysaccharide Vaccine) (Pneumovax 23)
- ❑ RZV (Recombinant Zoster Vaccine) (Shingrix)
- ❑ Tdap (Tetanus, Diphtheria, Pertussis) (Boostrix)
- ❑ Other _____

Vaccine[s] Administrator

- ❑ Alex Tucker, PharmD
- ❑ John Mark Carter, PharmD
- ❑ Bradley Gay, PharmD
- ❑ Jodie Tucker, PharmD
- ❑ Samantha Kerr, PharmD
- ❑ Other _____