

Vaccine Administration Record - Immunization Consent Form 2026 - 2027

Name (Please Print)		Date of Birth & Age		Sex	Social Security Number
Address		City	State	Zip	
Phone		Emergency Contact: Name, Relationship & Phone Number			
Medicare Number		Part D (RSV Eligible)	INTERNAL USE: Facility & Patient ID		

Please complete the questions below for yourself or the person receiving the vaccine.

- ☐ No ☐ Yes Are you currently sick with a fever?
☐ No ☐ Yes Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?
☐ No ☐ Yes Have you ever had a reaction after receiving a vaccine including dizziness or fainting?
☐ No ☐ Yes Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?
☐ No ☐ Yes Have you ever received the following vaccines? Pneumonia Y or N Date: _____ Shingles Y or N Date: _____ Whooping Cough Y or N Date: _____
☐ No ☐ Yes Are you a smoker?
☐ No ☐ Yes Do you have a chronic medical condition or long-term health problem? If yes, please describe: _____
☐ No ☐ Yes Do you have allergies to medications, food components, vaccine components, or latex? If yes, please list. Examples: eggs, bovine protein, gelatin, gentamicin, poliovirus, neomycin, phenol, yeast, thimerosal, (or a component of the covid-19 vaccine including but not limited to polyethylene glycol (PEG) or polysorbate) Allergies
☐ No ☐ Yes Are you currently pregnant?
☐ No ☐ Yes Do you have a history of asthma or wheezing?
☐ No ☐ Yes Are you a child or adolescent receiving long-term aspirin therapy?
☐ No ☐ Yes Do you have a condition that may weaken your immune system (e.g. cancer, lymphoma, leukemia, transplant, HIV/AIDS)?
☐ No ☐ Yes Are you currently receiving high dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?
☐ No ☐ Yes Are you currently receiving home infusions, weekly injections such as Humira, Embrel, high-dose methotrexates, antivirals, anticancer drugs or radiation therapy?
☐ No ☐ Yes Have you been given a blood transfusion, blood products, or been given a medication called immune (gamma) globulin in the past year?
☐ No ☐ Yes Do you have a history of thrombocytopenia or thrombocytopenic purpura?
☐ No ☐ Yes Have you received any other vaccinations within the last 4 weeks?
☐ No ☐ Yes Are you over 60 years of age? (RSV)
☐ No ☐ Yes Have you taken an antiviral medication for any diseases within the last 48 hours?

Please read the section below carefully and sign and date acknowledging that you understand and agree.

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; (c) a person authorized to consent for the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I give my consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist, nurse or technician, where permitted by law, employed by Care One Pharmacy Services LLC. I also release Care One Pharmacy Services LLC and its officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am not of legal age and have obtained the signed consent of a parent or guardian. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I have been advised that I should remain in the area for 15 minutes after the vaccination for observation. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician,

Signature of Recipient (OR POA) I give my consent to receive: FLU RSV PNEUMO COVID	Date
Signature of Recipient (OR POA) I do NOT give consent to receive: FLU RSV PNEUMO COVID	Date

Area Below To Be Completed by Vaccine Administrator

Influenza Vaccine	Route: _____	Manufacturer, Lot Number & VIS _____	Date _____
Dosage: 0.5ml ___ 0.25ml ___ LAIV ___			
Administration Site: Left Arm ___ Right Arm ___ Left Thigh ___ Right Thigh ___			
Pneumonia Vaccine	Route: _____	Manufacturer, Lot Number & VIS _____	Date _____
Vaccine Type : PCV20 ___ PCV21 ___			
Administration Site: Left Arm ___ Right Arm ___ Left Thigh ___ Right Thigh ___			
RSV Vaccine	Route: _____	Manufacturer, Lot Number & VIS _____	Date _____
Dosage: 0.5ml ___			
Administration Site: Left Arm ___ Right Arm ___ Left Thigh ___ Right Thigh ___			
Covid Vaccine	Route: _____	Manufacturer, Lot Number & VIS _____	Date _____
Dosage: _____			
Administration Site: Left Arm ___ Right Arm ___ Left Thigh ___ Right Thigh ___			

Vaccinator Signature & Date _____