Place Prescription Label Here

Consent Form for Medication Administration

Last Name________________________________First Name______________________Middle Initial______

Date of Birth_________________Address_____________________________________City_______________State__

Zip_____________Phone (______________)________________Last 4 of Social Security Number_______________

Name of Vaccines or Medication to be administered by pharmacist________________________________

1. **Are you allergic to any medications, food, latex or vaccine component (e.g. eggs, gelatin, neomycin, latex)?** **__Y __N if yes list____________________**
2. **Is this your first time receiving this vaccine?** **__Y __N**
3. **Do you have a fever or feeling sick today?** **__Y __N**
4. **Are you currently receiving aspirin therapy?** **__Y __N**
5. **Have you ever had a serious reaction to a vaccine in the past?** **__Y __N**
6. **Are you pregnant or may become pregnant within 30 days?** **__Y __N**
7. **Have you received any other vaccines or a skin test within the last 4 weeks?** **__Y __N**
8. **Have you had a seizure or other nervous system problems?** **__Y __N**
9. **Have you taken medications that weaken your immune system, such as cortisone, prednisone, or anticancer drugs, radiation treatments within the last 3 months?** **__Y __N**
10. **List any other medical conditions?____**

Consent and waiver: I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet(s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge the **standing order physician Dr. CR Magness** and the pharmacy, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result there from. I acknowledge that ***I have been offered a copy of the pharmacy's privacy policies according to HIPPA***. I assign payment of authorized insurance benefits due to me to be paid to the pharmacy and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the pharmacy to report any medications received to the appropriate state vaccine registry. I am aware that an immunization certified student pharmacist might be administering this medication. **I agree to wait near the vaccination area for approximately 15 minutes to receive treatment in case of adverse reaction.**

Vis/Monograph Received____ (patient initial here)

____**Date**__________________________

Patient Signature

VIS Date________________ (staff fill out) ----clinic use only below this line-------

Drug/Dose:_____________**Manufacturer**:______________ Place Vaccine Vial Sticker Here

Expiration Date:_________**Lot Number**:______________________

Route: SQ IM Nasal PO **Site**: LD RD LA RA RGluteal LGluteal Nasal Oral

Immunizer Signature:______________________________________ **Title**: ______________ **Date**:______________

Recorded in AR Vaccine Registry Date_________Initials___________