

Hannaford Pharmacy Vaccine Informed Consent Form

Name: _____ Date of Birth: ___/___/___ Age: ___ Gender: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Phone: (____) _____ - _____ Mother's Maiden Name (NY ONLY): _____
 Healthcare Practitioner: _____ Address: _____

Vaccine(s) to be given today: _____ / _____ / _____
 - (NH only) If you don't want Hannaford Bros. Co to notify your primary care physician about the vaccine(s) you are receiving today, please opt out by checking "NO" NO

The following questions will help us determine your eligibility to be vaccinated today. If any questions are unclear, please ask for assistance.	YES	NO
1. Do you feel sick today or currently have a fever or infection?		
2. Are you allergic to any medications, foods, or vaccines? (i.e. eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein)		
3. Have you ever had a severe reaction to any vaccine which required medical care?		
4. Do you have a long-term health problem with heart, lung, kidney, diabetes, asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy?		
5. Have you had a seizure, brain or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?		
6. Have you received Immune (gamma) Globulin or a transfusion of blood or plasma in the past year?		
7. Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?		
8. Are you, anyone in your home, or anyone you take care of being treated with prednisone, other steroids, weekly injections, anticancer drugs or radiation?		
9. Do you, anyone in your home, or anyone you take care of have cancer, HIV/AIDS or any other immune deficiency disorder?		
10. If <17 years of age: Are you currently taking aspirin or any aspirin-containing products?		
11. For women: Are you pregnant, nursing, or planning a pregnancy in the next 3 months?		
12. Have you received any vaccinations in the past 4 weeks?		

Check any chronic condition or age category below that applies to you:

Diabetes
 Asthma
 Smoker
 Heart Condition
 Lung Condition
 50 or older

Have you received the following vaccinations?

Influenza
 Pneumonia
 Meningitis
 Shingles (over 50)
 Tetanus
 Whooping Cough
 Hepatitis

I certify that I am: (i) the Patient and at least 18 years of age; (ii) the patient's personal representative. I consent to, or give consent for, the administration of the vaccine(s) marked below by a Hannaford pharmacist. Where applicable and accepted by state regulations, I consent to my vaccine being administered by a Hannaford pharmacy intern. I acknowledge I have the right to ask for a copy of the Hannaford Notice of Privacy Practices. I have read, or have had read to me, the Vaccine Information Statement (VIS) indicated below. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I authorize the information to be forwarded to my primary care physician, authorizing physician or local Dept. of Health/registry, if applicable. **I agree to stay in the general area for 20 minutes after receiving my vaccination in case any immediate reactions occur.** I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccine administration I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hannaford Pharmacy and its parent, subsidiary and affiliates, and its officers, employees and agents, respectively, from any & all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives.

X _____ Date: ___/___/___
 Signature of Patient or Patient's Personal Representative (A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient.)

FOR PHARMACIST USE ONLY							
Admin Date/ VIS Date Given	Vaccine	Vaccine Lot #	Exp Date	Manufacturer	Dose	Site of Injection PLUA: Post Lateral Upper Arm (SQ), Deltoid (IM)	VIS Date
						IM / SQ L / R Deltoid / PLUA	
						IM / SQ L / R Deltoid / PLUA	
						IM / SQ L / R Deltoid / PLUA	

-I have reviewed the Informed Consent Form to assess patient for potential contraindications and precautions to the vaccine(s) being administered today, and I have confirmed the vaccine(s) requested is/are indicated for this patient. **RPh Initials:** _____
 -I have received verbal consent to report vaccine(s) to the registry for patients age 19 and older (NY only). **RPh Initials:** _____
 -Certificate of Immunization given to patient YES NO -Copy sent to provider : YES NO

Pharmacist Signature/Title: _____ RPh _____ Date: _____
 Intern Signature: _____ Date: _____
 Location of Pharmacy/Administration: _____ Phone: _____