Waimanalo PHARMACY
41-1610 KALANIANAOLE HWY.
WAIMANALO, HAWAII 96795 PHONE 259-8488

Immunization Consent Form

PATIENT INFORMATION

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | MI | GENDER (M/F) | BIRTHDATE (MM/DD/YYYY)

ADDRESS | CITY | STATE | ZIPCODE

10-DIGIT PHONE NUMBER | PRIMARY CARE PROVIDER | PCP PHONE/FAX

INSURNACE INFORMATION

☐ CASH ☐ MEDICARE # ☐ INSURANCE CARRIER NAME ☐ GROUP # ☐ ID#

VACCINE(S) REQUESTED

☐ Influenza injectable ☐ Meningococcal ☐ Hepatitis A & B ☐ Zoster (Shingles) ☐ Measles Mumps & Rubella (MMR)

☐ COVID-19 ☐ Hepatitis A ☐ HPV ☐ Tetanus (Td) ☐ Other_____

☐ Pneumococcal ☐ Hepatitis b ☐ Varicella (Chickenpox) ☐ Whooping Cough (Tdap, DTaP) ☐ Other_____

PRE-SCREENING QUESTIONAIRE

Are you sick today? ..... ☐ Yes ☐ No

1. Do you have allergies to medications, food or vaccines? ..... ☐ Yes ☐ No
   Allergies_____
2. Have you ever had a serious reaction after receiving an vaccine? ☐Yes ☐No
3. Have you ever fainted/felt dizzy after receiving an immunization? ☐ Yes ☐No
4. Are you currently being treated for a long-term health problem such as heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? ..... ☐ Yes ☐ No
5. Are you currently taking cortisone, prednisone, other steroids or anti-cancer drugs, or have you had X-ray treatments? ..... ☐ Yes ☐ No
6. Are you currently being treated for Cancer, leukemia, AIDS or any other immune system problem? ..... ☐ Yes ☐ No
7. Have you had a seizure, brain or nerve problem? ..... ☐ Yes ☐ No
8. Do you have a history of Guillain-Barre Syndrome? ..... ☐ Yes ☐ No
9. During the past year, have you received a blood transfusion, blood products, or a medicine called immune (gamma) globulin? ..... ☐ Yes ☐ No
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month? ..... ☐ Yes ☐ No
11. Have you received any vaccinations in the past 4 weeks? ..... ☐ Yes ☐ No
    If yes, what vaccines?
    _____
12. Are you allergic to eggs? ..... ☐ Yes ☐ No
13. Are you allergic to latex? ..... ☐ Yes ☐ No

ADVERSE REACTIONS / CONSENT

Please read the following statements and sign and date below.

Consent for services, HIPAA Privacy Information and Medical Records. I have been provided with the Vaccine Information Sheet (VIS) and/or been provided with information regarding to the vaccine I am receiving. I understand all the benefits and risks of the vaccine and have had the chance to ask questions regarding it. I voluntarily assume full responsibility for any reactions that may result. I request the vaccine be given to me and authorize and direct this health care provider to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated by this provider (standing order practitioner (Dr._____), my Primary Care Physician (PCP), my insurance plan and/or state federal registries, where required for purposes of treatment, payment or other health care operations. This only allows this provider to disclose the following medical records: only documents related to the vaccination received today. This authorization will remain in effect until my health care provider discloses my health information to the recipient identified above; my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse or revoke this Authorization at any time. I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice. I have acknowledged that I have received the provider's Inc Notice of Privacy Practices which may be provided at my request. For Medicare Billing: I authorize this provider to release information and request payment. I understand that the information given by me in applying for payment is correct. I authorize the release of all records to act on this request and I request that payment of benefits be made on my behalf.

SIGNATURE/LEGAL GUARDIAN | PRINT NAME | DATE

TO BE COMPLETED BY PHARAMCY

Date | Administering Immunizer Name & Title

Vaccine	Manufacturer	Vaccine	Manufacturer
Lot#	Exp. Date	Lot#	Exp. Date
Vol	VIS Version	Vol	VIS Version
Site of Inj.	Rt of Admin.	Site of Inj.	Rt of Admin.