

HPV Vaccine Consent Form

(Gardasil 9)

Must be 15 to 26 years of age

Must remain in pharmacy for 10 minutes after injection



Schwieterman
PHARMACIES'
VACCINATION PROGRAM
Protecting Your Family's Health

PERSONAL INFORMATION

[PLACE RX LABEL HERE]	PATIENT PHONE: () -	
	DATE OF BIRTH: / /	AGE:
	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
	COUNTY:	
	FAMILY DOCTOR:	
	MEDICARE/COMMERCIAL INSURANCE ID:	

SCREENING QUESTIONS

1. Are you currently sick with a fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have a severe (life-threatening) allergy to yeast or any component (or part) of this vaccine, including vitamins, amino acids, mineral salts, carbohydrates, amorphous aluminum hydroxyphosphate sulfate, sodium chloride, L-histidine, polysorbate 80, and sodium borate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had a severe (life-threatening) reaction to a previous dose of any vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. For women: Are you breastfeeding, pregnant, or is there a chance you could become pregnant during the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in the Vaccine Information Statement about human papillomavirus (HPV) vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of HPV vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Dr. James Schwieterman, MD, Schwieterman Pharmacies, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contact HPV, other diseases, or suffer any other adverse reactions following administration of this HPV vaccine. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.



SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR LEGAL GUARDIAN) _____ DATE _____

-----FOR CLINIC/OFFICE USE ONLY-----

IMMUNIZER:			TITLE:	DATE OF IMMUNIZATION:
VACCINE/MFG/DOSAGE: Gardasil 9/Merck/0.5ml	LOT #:	EXP DATE:	SITE OF INJECTION: <input type="checkbox"/> LA/IM <input type="checkbox"/> RA/IM	VIS DATE: 12/2/2016
INSURANCE: <input type="checkbox"/> Medicare <input type="checkbox"/> Rx Coverage <input type="checkbox"/> Major Med <input type="checkbox"/> Cash <input type="checkbox"/> _____			STORE: <input type="checkbox"/> CL <input type="checkbox"/> CW <input type="checkbox"/> MIN <input type="checkbox"/> NB <input type="checkbox"/> SM <input type="checkbox"/> WP	

DOSE _____ of 3 (Dose 2 is given 2 months after Dose 1 & Dose 3 is given 4 months after Dose 2)

Updated Aug 2018